



# **OPERATIONS GUIDE**

**Division of Maternal and Infant Health  
Bureau of Family Health Services  
Population Health Administration  
Michigan Department of Health and Human Services**

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## SECTION 1 - INTRODUCTION and OVERVIEW

### PURPOSE OF THE MIHP OPERATIONS GUIDE

The *MIHP Operations Guide* is designed to be a comprehensive reference for MIHP providers and is intended to be used in conjunction with the *Medicaid Provider Manual*. The *Operations Guide* should not be construed as a substitute for the *Medicaid Provider Manual*.

Although the *MIHP Operations Guide* was conceptualized as a central and comprehensive source for providers to obtain answers to their MIHP questions, it is not intended to replace technical assistance offered by MDHHS MIHP consultants. MDHHS anticipates the primary users of the *MIHP Operations Guide* to be the following groups:

- Potential and new MIHP providers who need detailed program information for start-up purposes
- Newly-hired staff who need an orientation to MIHP
- MIHP staff who need to identify or verify program requirements or procedures
- Persons interested in learning how Michigan implements the MIHP

### OVERVIEW OF THE MATERNAL INFANT HEALTH PROGRAM (MIHP)

MIHP is Michigan's largest, evidence-based home visitation program for Medicaid eligible pregnant women and infants. The purpose of MIHP is to promote healthy pregnancies, positive birth outcomes and healthy infant growth and development with the long-term goal of reducing infant mortality and morbidity.

MIHP is a population-based, case management program. Population-based models address the health of the entire target population as well as the health of individuals within the population. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes." **(NCQA 2016 HP Standards and Guidelines)**

MIHP provides case management and health education services to Medicaid beneficiaries, focusing on the mother-infant dyad. MIHP promotes health equity and provides services targeting the psychosocial, nutritional and health risks specific to each pregnant woman and infant Medicaid beneficiary. MIHP services supplement prenatal and infant medical care and support the beneficiary in attaining health and well-being by identifying and addressing the impact of the social determinants of health.

During the pregnancy, the MIHP provider assists the woman to overcome barriers to obtaining prenatal care and to make changes that increase the likelihood that her infant will be healthy at birth. MIHP staff provides education on topics related to the woman's individual needs, offers guidance and encouragement as she endeavors to make changes, and facilitates referrals to other services and supports, as needed.

After the birth of the infant, the MIHP provider continues to support the mother and begins to monitor the infant's health, safety and development. The MIHP provider ensures that the infant has a medical care provider, encourages the mother, father or caregiver to take the infant to see the medical care

provider for regular well-child visits (and when medical care is indicated), and helps the mother follow through with the medical care provider's recommendations. The MIHP provider assists the mother to address any safety risks; administers standardized tools to screen for potential developmental delays/concerns; and refers the infant to Early On Michigan for a comprehensive developmental evaluation. The MIHP provider provides basic developmental guidance to promote infant health and development. The MIHP provider coordinates a full range of community resources and supports including child welfare services as indicated.

The ultimate, long-term goal of the MIHP is to reduce infant mortality and morbidity among the Medicaid population. "Infant mortality is a critical indicator of the overall health and wellness of all Michiganders and is a complex problem that can be more effectively understood and addressed using the *Life Course Model*. This includes a framework for how social determinants of health impact health outcomes for individuals, as well as whole groups of people. Life course looks at health as an integrated continuum and suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person's life."

**[Excerpted from the State of Michigan Infant Mortality Reduction Plan February 2016]**

Strong evidence for the effectiveness of the MIHP has been published in professional journals with the conclusion that the MIHP is effective in improving maternal prenatal and postnatal care and infant care.

### **Population Health Model**

In an effort to reduce infant mortality and morbidity among Medicaid pregnant women and infants, the Michigan Department of Health and Human Services (MDHHS) initiated the Maternal Support Services (MSS) Program in 1987 and the Infant Support Services (ISS) Program several years later. MSS was designed to address the psychosocial issues and logistical barriers that prevented many pregnant Medicaid beneficiaries from obtaining or benefitting from prenatal care. ISS was designed to promote health and development throughout infancy. MSS/ISS services were essentially home-based, delivered by a qualified team that included a registered nurse, a licensed social worker, a dietitian, and an infant mental health specialist (if available). MSS/ISS providers were given broad leeway in determining how services were delivered, resulting in a great deal of variation across providers. Data-reporting requirements were minimal.

In 2004, MDHHS undertook an effort to study and redesign MSS and ISS to improve program outcomes. As a result, MSS and ISS services were consolidated and renamed the **Maternal Infant Health Program (MIHP)**. The most significant redesign outcome was the decision to move to a **population management model**. **In MIHP, all pregnant and infant Medicaid beneficiaries are program-eligible.** MIHP providers strive to identify as many eligible women and infants as possible and to "touch" each one. At a minimum, this involves administering a risk identification tool and providing the beneficiary with an educational packet and a phone number, in case help is needed later in the pregnancy or infancy.

In a population management model the health of the entire target population is addressed in addition to the health of individuals within the population. Key features of the model include systematic risk screening; use of specified, evidence-based interventions tied to level of risk; case management; comprehensive data collection; a centralized database/registry; a strong focus on outcomes; and use of data to drive program decisions in order to improve program quality.

The MIHP population management approach requires providers to focus on the following:

- Engaging all Medicaid-eligible pregnant women and infants in MIHP.

- Identifying risk factors for all Medicaid-eligible women and infants in order to determine service intensity levels, using standardized *MIHP Risk Identifier* (assessment) tools that generate stratified health profiles.
- Developing a *Plan of Care* based on *Risk Identifier* results, beneficiary priorities, and professional judgment.
- Delivering prescribed, evidence-based interventions, targeting identified risks and beneficiary priorities.
- Measuring specified outcomes.

In addition to the key features noted above, the MIHP population-based model includes:

- Collaboration with significant stakeholders, including the women who participate in the program, to conduct program planning;
- Acknowledging that referrals, resources and systems of care that vary across regions/communities;
- Use of a MIHP database for population management purposes, including tracking, reporting, and outcomes measurement;
- The systematic and periodic identification of beneficiary risk using evidence-based tools;
- Prioritization of evidence-based and/or best practice interventions to address (1) identified risks, (2) anticipated service-intensity levels, and (3) specified domains/areas;
- Plans of care are tailored to individual beneficiaries based on readiness for change in addition to identified risks;
- Educational interventions are delivered by providers operating within the program policy and professional scope of practice;
- Providers meet program expectations, including implementation of outreach strategies;
- Providers are provided with ongoing training and oversight; and
- MIHP is evaluated annually using process and outcome-based metrics.

“Case coordination” and “case management” are terms used to describe an array of activities that help to link families to services, avoid duplication of effort, and improve communication between families and providers.

Case management is “a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual’s family, while promoting quality, cost-effective outcomes.” **(NCQA 2016 HP Standards and Guidelines)**

Case management employs motivational interviewing techniques, is characterized by client advocacy, encourages beneficiary empowerment and self-management, and promotes quality and improved outcomes. Communication among the beneficiary, medical care provider, Medicaid Health Plans (MHP) and community agencies is also a key component. (Excerpted from <http://www.cmsa.org/PolicyMaker/ResourceKit/AboutCaseManagers/tabid/141/Default.aspx>)

MIHP provides case management services to Medicaid beneficiaries using evidence-based educational interventions targeting the psychosocial, nutritional, and health risks specific to each pregnant woman and infant. MIHP providers supplement medical (prenatal and infant) care, assisting medical care providers to improve the beneficiary’s health and well-being by identifying and addressing these psychosocial, nutritional and health education needs.

### Program Administration

MIHP is jointly managed by two administrations within the Michigan Department of Health and Human Services (MDHHS): the Population Health Administration, Bureau of Family Health Services; and the Medical Services Administration/Bureau of Policy and Actuarial Services and Bureau of Medicaid Care Management and Quality Assurance, Managed Care Plan Division. The Bureau of Family Health Services/Division of Maternal and Infant Health is responsible for developing MIHP procedures, certifying and monitoring providers, and providing technical assistance to providers. The Medical Services Administration (MSA) is responsible for promulgating Medicaid policies, assisting providers to implement Medicaid policies, entering into and monitoring contracts with Medicaid Health Plans, and making payments to Medicaid providers.

MIHP also has multiple other internal and external partners invested in providing care and services to Michigan residents and advocating for positive maternal and child health outcomes.

MDHHS internal partners include:

- Medicaid Managed Care Division
- Medicaid Program Policy Division
- Michigan Children's Protective Services
- WIC Division
- Division of Immunization
- Division of Maternal and Child Health
- Division of Child and Adolescent Health
- Title V – Block Grant Program
- Title X – Family Planning
- Bureau of Epidemiology & Population Health
- Michigan Home Visiting Initiative (MIECHV)
- The Children's Trust Fund
- Behavioral Health and Developmental Disabilities Administration

External organizations represent:

- Michigan Medicaid Health Plans
- Michigan Council for Maternal & Child Health
- March of Dimes
- Michigan Department of Education – Early On, Early Head Start
- Community Mental Health/PIHPs
- Infant Mental Health
- Hospital systems
- Statewide organizations (Michigan Health and Hospital Association, Michigan Association of Health Plans, Michigan Association for Local Public Health, etc.)
- Local Public Health Departments
- Federally Qualified Health Centers
- Inter-Tribal Council
- Michigan Universities
- Michigan Public Health Institute

Collaboration is ongoing and includes discussion related to ongoing research and objectives; study findings; programmatic, policy, and population health implications; home visiting standards and metrics; and national and state legislative mandates.

### Goal of MIHP

As previously stated, the goal of MIHP is to support Medicaid beneficiaries to ***promote healthy pregnancies, positive birth outcomes, and infant health and development***. MIHP services are intended to supplement medical prenatal and infant care and support the beneficiary in attaining health and well-being by identifying and addressing the impact of the social determinants of health. MIHP promotes health equity and provides case management and health education intervention services, focusing on the mother-infant dyad.

The ultimate, ***long-term goal of the MIHP is to reduce infant mortality and morbidity*** among the Medicaid population. Infant mortality is a critical indicator of the overall health and wellness of a population and the quality of health care.

(Citation: AMCHP: <http://www.amchp.org/programsandtopics/data-assessment/InfantMortalityToolkit/Documents/Why%20Focus%20on%20IM.pdf>)

### Infant Mortality Rates in Michigan

Infant mortality rates in Michigan indicate significant health disparities among population groups. Michigan's overall infant mortality rate was 6.8 deaths per 1000 live births based on 2013-2015 data (three-year average). Racial and ethnic disparities persist; as shown below, the Black, Hispanic, Middle Eastern and American Indian rates remain higher than the White rate:

- White: 5.4/1000
- Black: 13.4/1000
- Hispanic: 9.4/1000
- Middle Eastern: 5.8/1000
- Asian and Pacific Islander: 4.0/1000
- American Indian: 9.8/1000

(Source: Michigan League for Public Policy, August, 2017)

### Practices to Reduce Infant Mortality through Equity (PRIME)

Funded through the W.K. Kellogg Foundation, the MDHHS Bureau of Family Health Services developed Practices to Reduce Infant Mortality through Equity (PRIME), a project to reduce racial disparities in infant mortality between Blacks and Whites and between American Indians and Whites in Michigan. The intent of the project was to develop a quality assurance process that included increased monitoring of social determinants of health: the social and economic conditions in which people are born, grow, live, work and age. The key was to identify how the determinants impact infant mortality and implement strategies at the state, local and program levels to aid in decreasing the number of infant deaths in Michigan. The initial PRIME projects have concluded however, sustainable strategies continue to be implemented throughout the Bureau.

### The Trauma-Informed Approach

In recent years, the impact of trauma and toxic stress across the life course has been well documented with input from scientists in the fields of neuroscience, genetics, immunology, psychology and epidemiology. Children and adolescents are particularly vulnerable to individual traumatic events but even more so to chronic or toxic stress, which impacts physical, cognitive, emotional and social development. The developmental impact in turn affects health and mental health outcomes across the life course.

The terms trauma-informed care or trauma-informed approach are used to describe activities that seek to prevent and treat the impact of trauma and toxic stress and to support and build resilience. In

maternal and child health programs, the focus on prevention and early intervention creates an opportunity to apply trauma-informed principles in a context that emphasizes protective factors and resilience, as well as healing. The trauma-informed approach at its core is compassionate care that recognizes the prevalence of trauma and its impact and attempts to develop or restore a sense of safety, self-efficacy and empowerment for those that seek services. Although specific practices vary, all trauma-informed approaches should incorporate the six key principles described by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). The principles are - safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues. For more information visit: [www.michigan.gov/traumatoxicstress](http://www.michigan.gov/traumatoxicstress) and <https://www.acf.hhs.gov/trauma-toolkit>.

### **Other MDHHS Approaches to Combat Infant Mortality**

In recognition of the complexity of the infant mortality problem, MDHHS has several other approaches that, in addition to MIHP and PRIME, are intended to help combat infant mortality. These initiatives include the State of Michigan's Infant Mortality Reduction and Prevention Initiative, Fetal-Infant Mortality Review Program, Michigan Maternal Mortality Surveillance, Reproductive and Preconception Health Program, Perinatal Care System, Quality Improvement, Breastfeeding Promotion Program, Fetal Alcohol Spectrum Disorders Program, Safe Delivery of Newborns Program, Infant Safe Sleep Initiative, Eliminating Non-Medically Indicated Elective Delivery before 39 Weeks Initiative, and the Maternal, Infant and Early Childhood Home Visiting Program.

The ***Michigan 2016-2019 Infant Mortality Reduction Plan*** takes into consideration the role that racial disparities and the social determinants play in determining infant mortality rates (Goal #1 of the Plan). It focuses on strategies geared toward the highest risk families and communities. This approach ensures that everyone who lives in Michigan has health care and that socioeconomic determinants of health are addressed to achieve and sustain health and wellness. To improve the number of Michigan infants who survive and thrive requires purposeful, measurable movement toward improved health equity, which is a key focus of the state's Plan." This is highlighted in Goal #6 of the Plan; expanding home visiting programs such as MIHP to promote healthy women and children. **[State of Michigan Infant Mortality Reduction Plan February 2016 <http://www.michigan.gov/infantmortality/0,5312,7-306-64191-296542--00.html>]**

***Social determinants of health***—often defined as the circumstances in which people are born, grow up, live, work, play and pray—shape individual behavior and the choices that are available to individuals for improving health. Some individuals, and specific groups of people, do not have the same access to health care and have limited choices for improving health. Access to health care and healthy behaviors are important, but social determinants of health can have a greater impact on health and birth outcomes. These factors can adversely impact health when nutritious food, transportation, safe housing, education, livable and/or sustainable wages are not available or are very difficult to obtain. Persistent health inequities among people of color and/or those living in poverty are directly related to their living conditions and personal experiences, and these factors must be addressed in any plan designed to improve birth outcomes of all people. To eliminate these inequities, experts in infant mortality across Michigan are working to understand the contributing health determinants from historical, social, and cultural perspectives for each population group where the rate of poor outcomes is higher than it is for more advantaged populations. Partnerships and strategies to address social determinants of health requires an interdisciplinary approach including partners in public health, housing, employment, and the

court system to improve the support systems for those most adversely impacted by socioeconomic and racial disparities.

A fishbone diagram titled *Social Determinants and Contributing Factors for Infant Mortality* and a document titled *Health Disparities and Social Justice List of Definitions* (link is titled *Health Disparities Definitions*) are at the MIHP website under the heading “New Employee and Waiver Staff.”

### **MIHP Eligibility**

MIHP services are a Medicaid-only benefit. All pregnant women and infants enrolled in the following Medicaid programs are eligible for MIHP:

- Healthy Kids for Pregnant Women and Children
- Group 2 Pregnant Women Program
- U-19
- MICHild
- Healthy Michigan Plan
- Maternity Outpatient Medical Services (MOMS)

Pregnant Medicaid beneficiaries qualify for MIHP services at any time during the pregnancy. For purposes of closing a case, maternal services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls.

MIHP services for an infant begin after the infant's birth and hospital discharge. Infant services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family (e.g., maternal/infant dyad, father, grandparent).

### **Medicaid Enrollment**

Most pregnant Medicaid beneficiaries are required to enroll in a Medicaid Health Plan (MHP) although there are some exceptions. Voluntary populations may choose to enroll in a MHP or to select Fee-For-Service coverage. Voluntary populations include: migrants, American Indians, and most individuals who are dually Medicare/Medicaid eligible. Women in the MOMS Program are not eligible to enroll in a MHP.

If a mother is enrolled in a MHP at the time of the birth of her baby, the baby will be enrolled in that same plan for at least the month of birth. The family could prospectively choose a different MHP for the infant. The infant's eligibility continues for 12 continuous months without any interruption or spend-down. If risks are identified that may necessitate administration of an Infant Risk Identifier for a child older than 12 months of age or a MIHP professional visit beyond 18 months of age, the MIHP provider must obtain written authorization from the MDHHS MIHP Consultant prior to the visit for all beneficiaries. **Source: Medicaid Provider Manual** <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

MIHP serves the mother-infant dyad from early in the pregnancy, through the postpartum period, and throughout infancy, to the extent of maximizing authorized visits to meet Plan of Care objectives. However, a Medicaid-eligible pregnant woman may enroll in MIHP at any point during her pregnancy and a Medicaid-eligible infant may be enrolled in MIHP at any point during infancy up to 12 months of age.

### MIHP Providers

There are *CERTIFIED* MIHP providers throughout Michigan, each serving one or more counties. MIHP providers include: local public health departments, federally qualified health centers, tribal agencies, community-based organizations, and private entities such as hospitals, home health agencies, and individually-owned businesses. MDHHS encourages grassroots community and faith-based organizations not affiliated with an existing health care delivery system to apply for MIHP certification. MDHHS also encourages the start-up of small businesses in under-resourced neighborhoods. The goal is to increase the number of MIHP providers, who are willing and able successfully meet program requirements, to conduct extensive outreach to hard-to-reach pregnant women and infants across multiple geographic locations in the state.

### MIHP Service Process

MIHP is a home-visiting program, providing case management and health education for pregnant and infant Medicaid beneficiaries. MIHP providers make use of available community resources and provide health education and support to address the beneficiary's identified risk across multiple domains of care.

Once a potential beneficiary has agreed to a face-to-face meeting and signed the *Consent to Participate in the Risk Identifier Interview/Consent to Participate in MIHP and the Consent to Release Protected Health Information*, the MIHP provider uses a standardized, system-wide service process, involving the following components:

1. Administration of the evidence-based *Maternal or Infant Risk Identifier*.
2. Assisting the beneficiary to identify her individual needs, goals, and resources.
3. Facilitating the development of an individualized, evidence-based *Plan of Care*, incorporating the beneficiary's stated needs, goals, and resources.
4. Assisting the beneficiary to locate and access resources.
5. Facilitating connections with providers of services and supports; advocating on behalf of the beneficiary to obtain services, if needed.
6. Providing educational and other services as indicated in the *Plan of Care* during visits.
7. Coordinating, implementing and updating the *Plan of Care*; ensuring that services are rendered, monitoring beneficiary's use of services, and coordinating services when multiple providers are involved.
8. Assisting the beneficiary with problematic situations and needs, as they arise with a focus on the social determinants of health.
9. Using Motivational Interviewing and coaching the beneficiary toward self-empowerment and self-management.
10. Maintaining communication with the beneficiary to evaluate whether the *Plan of Care* is effective in meeting the beneficiary's goals.
11. Modifying the *Plan of Care*, as needed.
12. Communicating with medical care provider and Medicaid Health Plan.
13. Determining if specified, desired service outcomes are achieved.
14. Assuring linkage to appropriate health and community resources at program discharge
15. Assuring continuity of health care, and community and social supports.

### **Partners in Providing Coordinated Care for MIHP Beneficiaries**

MIHP serves the mother-infant dyad, ideally from early in the pregnancy, through the postpartum period (immediately after the birth of a child and extending about six weeks), and throughout infancy to the extent of maximizing authorized visits to meet *Plan of Care* objectives. The MIHP provider, Medicaid Health Plan (MHP), and medical care provider are active partners in assuring that MIHP beneficiaries are systematically identified and provided with quality, coordinated care.

### **Coordination with Medicaid Health Plans**

Pregnant and infant Medicaid beneficiaries are required to enroll in Medicaid Health Plans (MHPs), with few defined exceptions. MDHHS contracts with MHPs to provide medical health care, mental health care for mild to moderate mental health concerns, transportation, and case management for Medicaid beneficiaries. (Mental health care for individuals with serious mental illness is carved out from the MHPs and provided by Community Mental Health Services Programs.) As of January 2017, MDHHS holds contracts with 11 health plans in a targeted geographical service areas comprised of 83 counties divided into 10 Prosperity Regions.

Medicaid has consistently encouraged the MIHP providers and MHPs to collaborate and coordinate services for mutually-served beneficiaries, reimbursing all MIHP providers on a Fee-For-Service basis through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS).

***Effective January 1, 2017, MIHP services provided to individuals enrolled in a MHP are administered by the MHP.*** As a result of this change, all MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHP. MIHP providers are encouraged to contract with the MHPs in their service area(s); contracts are directly negotiated between the MHP and MIHP agency.

In addition, MIHP providers and MHPs serving a common county or group of counties are to establish and maintain an ***MIHP - MHP Care Coordination Agreement (CCA)*** for both in-network and out-of-network services. The intent of the CCA is to define the responsibilities and relationship between the MHP and the MIHP provider. In addition, the CCA describes the services and essential aspects of collaboration between the MHP and the MIHP provider (e.g., medical coordination, transportation, quality improvement, grievances and appeals, and dispute resolution) as well as communication expectations.

Under the scope of Medicaid policy, MHPs must refer all pregnant enrollees to an MIHP provider or another appropriate evidence-based home visiting program. MIHP providers and MHPs must adhere to the program components as outlined in the MIHP Chapter of the Medicaid Provider Manual, including (but not limited to): MDHHS program certification, required professional staff qualifications, and the use of MDHHS MIHP forms.

MIHP services for Fee-For-Service (FFS) beneficiaries continue to be reimbursed through CHAMPS. A MIHP that provides services to a FFS beneficiary may continue to provide services after the beneficiary enrolls in a MHP. The MHP is required to reimburse the MIHP until case closure, even if the MHP does not have a contract with the MIHP.

### **Coordination with Medical Care Providers**

In addition to coordinating with the MHP responsible for overall management of the beneficiary's health care, the MIHP provider must coordinate with the beneficiary's medical care provider. The medical care

provider may be a physician, certified nurse midwife, pediatric nurse practitioner, family nurse practitioner, or physician assistant.

Since the MIHP provider and medical care provider are both striving to ensure that the beneficiary has the best possible care, it's important that they communicate regularly. Medicaid policy specifies points at which the MIHP provider must inform the medical care provider about the beneficiary's status. MDHHS further requires the MIHP provider to share beneficiary information with the medical care provider using standardized forms. For example, when an MIHP case is opened without the medical care provider's involvement, the MIHP provider must notify the medical provider within 14 calendar days.

### **Coordination with Community Resources and Supports**

Strong relationships with key referral sources are required to provide quality care coordination services. MIHP professionals are required to refer beneficiaries to community service providers and support systems based on the beneficiary's needs/risks and according to the interventions associated with each domain of care. MIHP providers are also required to follow-up on referrals to determine whether or not a beneficiary accessed the services. In addition, MIHP agencies are required to maintain a current list of community agencies that may have appropriate services to offer the beneficiary.

There are key referral sources with which MIHP providers should cultivate good working relationships. Examples include registered dietitians (RD) and infant mental health (IMH) specialists (if not on staff); Early On; Community Mental Health; MHP behavioral health care managers; and substance use disorder and domestic violence programs.

### **Description of MIHP Services**

MIHP provides case management and education services for maternal/infant dyads with a focus on addressing the social determinants of health. Program services include social work, nursing services (including health education and nutrition education), breast feeding support, nutritional counseling, and beneficiary advocacy services.

MIHP services include:

- Psychosocial and nutritional assessment
- Plan of care development
- Professional intervention services
- Maternal and infant health and nutrition education/counseling
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments
- Referral to and coordination of community services (e.g., mental health, substance abuse)
- Coordination with other medical care providers and Medicaid Health Plans (MHPs)
- Reproductive planning, education and referral
- Coordinating or providing childbirth or parenting education classes

**Case Management services** are provided by a registered nurse or a licensed social worker, one of whom is designated as the Case Manager. The Case Manager is responsible for coordinating and monitoring all services provided to the beneficiary, including referrals and follow-up. It is the role of the case manager to advocate for the beneficiary when necessary and ensure that she is involved in her own care plan

development and service arrangements to the greatest possible extent. It is the ultimate objective of the provider to empower the beneficiary to successfully navigate the health care system.

**Education services** are provided by a registered nurse, a licensed social worker, a registered dietitian (with a physician order), or an infant mental health specialist. MIHP staff providing these services use a supportive approach based on Motivational Interviewing principles.

***MIHP professional staff qualifications, license/certification and verification requirements are outlined in Medicaid policy***

### **The MIHP Operations Guide**

The *MIHP Operations Guide* is designed to be a comprehensive reference for MIHP providers and is intended to be used in conjunction with the *Medicaid Provider Manual*. The *Operations Guide* should not be construed as a substitute for the *Medicaid Provider Manual*.

Although the *MIHP Operations Guide* was conceptualized as a central and comprehensive source for providers to obtain answers to their MIHP questions, it is not intended to replace technical assistance offered by MDHHS MIHP consultants. MDHHS anticipates the primary users of the *MIHP Operations Guide* to be the following groups:

- Potential and new MIHP providers who need detailed program information for start-up purposes
- Newly-hired staff who need an orientation to MIHP
- MIHP staff who need to identify or verify program requirements or procedures
- Persons interested in learning how Michigan implements the MIHP

### **How to Use the MIHP Operations Guide**

The authoritative source for the Maternal Infant Health Program (MIHP) is the *Medicaid Provider Manual* which can be accessed at [Medicaid Provider Manual](#). The *MIHP Operations Guide* is to be used with MIHP policies in the *Medicaid Provider Manual*. Medicaid policy is not incorporated within the *MIHP Operations Guide*. MIHP providers should be very familiar with both documents.

To locate information about a particular topic in the *MIHP Operations Guide*, start with the Table of Contents or use the “find” function. If you can’t find what you’re looking for, please contact one of the MDHHS MIHP consultants identified in the following section.

The *MIHP Operations Guide* is only available electronically. It is updated quarterly in conjunction with *Medicaid Provider Manual* policy updates. Providers are strongly encouraged to make it a practice to refer to the electronic *Operations Guide*. If you do print out a particular section for ease of use, it is your responsibility to ensure that you are always working from the most recent version incorporating all updates.

The Michigan Department of Health and Human Services (MDHHS) wants to make the *MIHP Operations Guide* as user-friendly as possible. MDHHS welcomes your feedback. Please forward questions or comments about the *Operations Guide* to one of the consultants listed below.

## MDHHS MIHP Consultant Contact Information

<b>Ingrid Davis, MPA</b> MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Phone: 517 335-9546 Fax: 517 763-0366 Email: <a href="mailto:davis1@michigan.gov">davis1@michigan.gov</a>	<b>Joni Detwiler, MSW</b> MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Phone: 517 335-6659 Fax: 517 763-0366 Email: <a href="mailto:detwilerj@michigan.gov">detwilerj@michigan.gov</a>
<b>Chelsea Low, LLMSW</b> MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Phone: 517 241-6144 Fax: 517 763-0366 Email: <a href="mailto:lowc@michigan.gov">lowc@michigan.gov</a>	<b>Cherie Ross, LMSW</b> MIHP Program Consultant Division of Maternal and Infant Health Michigan Department of Health and Human Services Phone: 517 373-2458 Fax: 517 763-0366 Email: <a href="mailto:rossjordanc@michigan.gov">rossjordanc@michigan.gov</a>

### Mailing Address:

PO Box 30195  
Lansing, MI 48909

## MIHP Website

MDHHS maintains an MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). The site includes:

- A brief overview of the program
- Information on locating MIHPs across the state
- Information on becoming an MIHP provider
- MIHP forms and forms instructions
- MIHP trainings
- Resources
- MIHP news
- Other items of interest to MIHP providers, prospective providers and families

## MIHP Coordinators Directory

The *MIHP Coordinators Directory* includes updated contact information for each MIHP provider, including the names of the coordinator and a secondary contact person. An email address and phone number is given for the secondary contact person. The secondary contact may or may not be another staff person.

The *Directory* also lists the counties served by each MIHP. As a Medicaid provider, you may select the counties you wish to serve. In order to list a county in the *Directory*, you must be willing to serve the county in its entirety.

The *Directory* also indicates the name the agency's MDHHS MIHP assigned consultant and contact information, as well as MIHPs that offer childbirth education and/or parenting education for beneficiaries served by other MIHPs.

The *Directory* is at the MIHP website. It is updated frequently, so be sure to use the most recent version. The *Directory* is maintained as an Excel spreadsheet, which allows you to sort MIHP providers by county.

It is important that you are diligent about reporting any changes to MDHHS so that your contact information is always current to ensure you receive important communications from MDHHS.

### MIHP Specialty Providers

The *MIHP Coordinators Directory* also indicates which providers have been designated as specialty providers by MDHHS. A specialty provider serves one or more of the following population groups: Arabic speakers, Spanish speakers, refugees, migrants, Native American/American Indians, persons who are deaf or hard of hearing, persons who are blind or visually impaired, adolescents, and veterans. This information is useful to people who are referring a particular individual to an MIHP and are looking for the best possible fit.

Criteria that must be met to be designated as a specialty provider:

1. Provider's outreach activities are directed toward the population.
2. Persons in the specialty population group are served by the provider.
3. Outreach and educational materials are written in the language of the population (if applicable).
4. Provider has at least one staff who speaks the language of the population (if applicable).
5. Staff have participated in some form of training (e.g., online) on serving the population.

The *MIHP Specialty Provider Attestation Form* and instructions for completing the form are at the MIHP website. By signing the form, the provider is verifying that the information documented therein is factual and valid. The completed form must be submitted to your MDHHS MIHP consultant, who will determine whether or not your MIHP meets the criteria for designation. As of June 1, 2017, this applies to all MIHP providers, new and existing. You must notify your MIHP consultant within 14 days if your agency is no longer meeting the designation criteria.

If you serve some beneficiaries who speak a language other than English, you are not required to apply for specialty provider designation.

## **Maternal Infant Health Program (MIHP) Email Addresses**

MDHHS MIHP has three different email addresses for sending and receiving MIHP documents. Please be careful to use the correct address when submitting the documents and communications specified below:

### [NewProviderApplication@michigan.gov](mailto:NewProviderApplication@michigan.gov)

- Inquiries about becoming a new MIHP provider

### [MIHP@michigan.gov](mailto:MIHP@michigan.gov)

- Submission of *MIHP Personnel Rosters*
- Submission of changes to the *MIHP Coordinators Directory* (e.g., change of address, phone, fax, counties served, etc.)
- Submission of complaints; use encrypted software if beneficiary is named (complaints can also be submitted via fax or mail)

[MDHHS-MIHPCertification@michigan.gov](mailto:MDHHS-MIHPCertification@michigan.gov)

- Communications related to certification review documents
- *Corrective Action Plans*

Please use the above e-mail addresses as directed. Always use the consultant's email address when communicating with your consultant. **Do not cc any of these mailboxes when you send an email to your MIHP consultant.**

## SECTION 2 - MEDICAID PROVIDER RESOURCES

Medicaid providers must be familiar with Medicaid policies, procedures, and forms, including those pertaining to covered services and billing, all of which are subject to change. Providers are responsible for implementing changes in policies and procedures as of the dates they become effective. The resources described below are intended to assist MIHP providers in their ongoing efforts to keep current on the Medicaid program.

### The Centers for Medicare & Medicaid Services

As Medicaid providers, MIHPs are expected to follow all pertinent regulations and guidance issued by The Centers for Medicare & Medicaid Services (CMS), US Department of Health and Human Services. CMS administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and parts of the Affordable Care Act. The CMS website can be accessed at [www.cms.gov/](http://www.cms.gov/).

### Medicaid Policy Manual Website

The *Medicaid Provider Manual* can be accessed at [Medicaid Provider Manual](#). The *Manual* addresses all health insurance programs administered by the MDHHS.

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation. Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

Updates to the Medicaid Provider Manual, including contact information contained in the Directory Appendix, are made on a quarterly basis to reflect information that has been added, deleted, or changed via policy bulletins and other communications during the previous quarter. For this reason, providers are encouraged to utilize the electronic format of this manual. A policy bulletin, detailing the manual changes made each quarter, is sent to all Medicaid enrolled providers.

To review the MIHP chapter in the [Medicaid Provider Manual](#) in its entirety, click on "Maternal Infant Health Program" in the bookmarks column. MIHP providers must also be familiar with other relevant chapters in the *Medicaid Provider Manual*, including, but not limited to, the following:

- |  |                       |
|--|-----------------------|
| - Medicaid Provider Manual Overview            | - Family Planning     |
| - General Information for Providers            | - MI Health Link      |
| - Beneficiary Eligibility                      | - MI Choice Waiver    |
| - Coordination of Benefits                     | - Special Programs    |
| - Billing and Reimbursement for Professionals  | - Urgent Care Centers |
| - Children's Special Health Care Services      | - Appendices          |
| - Healthy Michigan Plan                        | - Acronyms            |
| - Emergency Services Only Medicaid             | - Directory           |
| - Maternity Outpatient Medical Services (MOMS) | - Glossary            |
| - Medicaid Health Plans                        | - Forms               |

### Medicaid Provider Website

MDHHS maintains a website for Medicaid providers at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). It provides direct links to information on a variety of topics including: Provider Enrollment, Eligibility Verification

System, Policy and Forms (including Michigan Medicaid Approved Policy Bulletins), Draft Policy Bulletins for Public Comment, Billing and Reimbursement, and Communications and Training.

## Michigan Medicaid Policy Bulletins

Michigan Medicaid Approved Policy Bulletins and Michigan Medicaid Proposed Policies are available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Policy and Forms.” As a Medicaid provider, you are responsible for thoroughly reading all Medicaid bulletins pertaining to MIHP as you receive them. Often, the final policy has been changed from the proposed policy; it is important that you read the final policy very carefully.

If you would like to receive copies of Notices of Proposed Policy, fill out the [MSA-0209](#) Request to Participate in Policy Proposal Review. This form is provided to you in MS Word format. Please fax the completed form to (517) 335-5136 or email to [MSADraftPolicy@michigan.gov](mailto:MSADraftPolicy@michigan.gov)

## Billing and Reimbursement

Information about Community Health Automated Medicaid Processing System (CHAMPS) enrollment and procedures, Medicaid provider billing and reimbursement, including electronic billing, explanation codes, National Provider Identifier (NPI) Registry, provider specific information, and fraud and abuse reporting requirements, is available at: [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Billing and Reimbursement.” Provider Updates – Medicaid Alerts, including Biller “B” Aware notices, are available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Sign up for alerts from both Medicaid and CHAMPS to ensure that you are receiving information regarding policy updates and upcoming Medicaid/CHAMPS opportunities at [http://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_5100-145006--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-145006--,00.html)

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be found at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Billing and Reimbursement,” then on “Provider Specific Information,” and then on “Maternal Infant Health Program.” This database is updated at least once annually. [Billing and Reimbursement](#) is a direct link to the database. The database is also accessible from the MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp). Click on “Providers, then “Current Providers,” then “Policy and Operations,” and then “MIHP Medicaid Fee Database and Instructions.”

## Billing Training

Communications and training information for billing agents is available at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Click on “Communications and Training.”

There is also an online training titled *Overview of Maternal Infant Health Program Training Course*, which is required for all MIHP provider applicants and billers. This training may be accessed at the MIHP website.

## Medicaid Provider Helpline

### CHAMPS Enrollment/Michigan Medicaid Provider Support

Providers with questions about Medicaid billing may call the toll-free number: **1-800-292-2550** or send an e-mail to: [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov) with “ATTN: Julie Withers” in the subject line. Write “MIHP

Question” in the body of the email and include a brief explanation of your situation and question. Provider Support will contact you.

## **MIHP Medicaid Provider Forms and Instructions**

MIHP providers must use standardized forms developed by MDHHS. The forms are available at the MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp) under the “Providers,” “Current Providers,” and then “Required Forms.”

## **Requests for Records from CMS/PERM**

The Payment Error Rate Measurement (PERM) is The Centers for Medicare & Medicaid Services (CMS) program in which information is requested from providers to support appropriate billing practices. Information about PERM can be found at the MDHHS website under (PERM Provider Education). Helpful information is also located at [Payment Error Rate Measurement \(PERM\) - Centers for Medicare](#).

## **Reporting Suspected Medicaid Fraud, Waste or Abuse**

The MDHHS Office of Inspector General (OIG) audits Medicaid claims and investigates suspected fraud, waste, and abuse. The OIG recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation and prosecution. To report suspected Medicaid fraud, waste or abuse to the OIG, call the Medicaid Fraud Hotline (toll free) at 855-MI-FRAUD (643-7283) or submit an online complaint at [MDHHS - Report Medicaid Fraud and Abuse - State of Michigan](#).

## SECTION 3 - MIHP GOAL AND PRIMARY PARTNERS

All pregnant and infant beneficiaries enrolled in the following Medicaid programs are eligible for MIHP: Healthy Kids for Pregnant Women and Children, Group 2 Pregnant Women Program, U-19, MICHild, Maternity Outpatient Medical Services (MOMS), and Healthy Michigan Plan. Beneficiaries at highest risk for pregnancy complications, poor birth outcomes, and delays in infant growth and development are offered MIHP services to address these concerns; beneficiaries at lower risk for these negative outcomes are offered services that correspond to their needs.

As MIHP services are intended to supplement medical (prenatal and infant) care, MIHP providers closely coordinate their efforts with medical care providers and with Medicaid Health Plans (MHPs). Most pregnant and infant MIHP beneficiaries are, or will soon become, MHP members.

### Description of Medicaid Health Plans

Medicaid Health Plans (MHPs) are managed care organizations that provide or arrange for the delivery of comprehensive health services to Medicaid enrollees in exchange for a fixed prepaid sum or per-member-per-month prepaid payment. An MHP must have a certificate of authority from the State as a Health Maintenance Organization (HMO).

MDHHS contracts with MHPs to provide medical health care, out-patient mental health care for mild or moderate mental health concerns, MIHP services, transportation, and case management for Medicaid beneficiaries. Mental health care for individuals with serious mental illness is carved out from the MHPs and provided by Community Mental Health Services Programs.

The State of Michigan is divided into ten Prosperity Regions. Each MHP serves one or more of these regions. Go to [View a map of the recommended health plans listed by prosperity region >>](#) for a list of MHPs serving each Prosperity Region.

MHPs may provide incentives to their members to encourage them to use prenatal and pediatric care. Once a MIHP beneficiary is enrolled in a MHP, the MIHP provider may encourage the beneficiary to take advantage of the incentives that may be offered by her MHP for completing prenatal care visits, the postpartum visit, and well-child visits.

### Mandatory Enrollment of Pregnant Women into Medicaid Health Plans

Most pregnant Medicaid beneficiaries are required to enroll in a Medicaid Health Plan (MHP), although there are some exceptions. Voluntary populations may choose to enroll in an MHP or to select Fee-For-Service coverage. Voluntary populations include: Migrants, American Indians, and most individuals who are dually Medicare/Medicaid eligible. Women in the MOMS Program are not eligible to enroll in an MHP.

### Michigan Enrolls

Michigan Department of Health and Human Services (MDHHS) contracts with MAXIMUS, Inc. to enroll Medicaid beneficiaries in Medicaid Health Plans (MHPs). This service is called *Michigan Enrolls*. After a pregnant woman's Medicaid application is approved, she receives a letter from Michigan Enrolls, asking her to select an MHP. Michigan Enrolls phone counselors (1-888-367-6557) are available to answer her general questions about Medicaid benefits (including MIHP), provide information on which doctors, pharmacies and hospitals are part of each MHP, and help her choose a plan. MIHP providers also may

help a woman choose an MHP, if she needs assistance. If the woman does not select an MHP within 30 days, she is automatically assigned to one.

### **Infant Automatically Enrolled in Mother's Health Plan**

If a mother is enrolled in a Medicaid Health Plan (MHP) at the time of the birth of her baby, the baby will be enrolled in that same plan for at least the month of birth. The family could prospectively choose a different MHP for the infant. The infant's eligibility continues for 12 continuous months without any interruption or spend down. MHP responsibilities begin at the time of the child's birth. The mother must report the birth to the Michigan Department of Health and Human Services in order to obtain the infant's Medicaid ID number, which providers must have in order to be able to submit Medicaid billings.

### **Accessing Information about Medicaid Health Plans**

There are approximately 11 Medicaid Health Plans (MHPs) operating in Michigan at any given time. A list of MHPs by county, MHP contact info, MHP enrollment data, and a sample standardized MHP contract are available at: [Medicaid Health Plans State of Michigan](#). Contact information may also be accessed at the MIHP website.

### **MIHP Providers, Medicaid Health Plans, and Medical Care Providers: Partners in Providing Collaborative Care for MIHP Beneficiaries**

MIHP providers collaborate with the Medicaid health plans, prenatal and pediatric providers, and community resource partners to systematically identify and provide equitable, quality, case management for pregnant mothers, infants and their caregivers.

### **Medicaid Health Plan Administers MIHP Services to its Members**

MIHP services provided to individuals in a Medicaid Health Plan (MHP) are administered by the MHP. This means that all services provided to MIHP enrollees are coordinated and reimbursed by the MHP.

MHP administration of MIHP is described in the following documents:

1. The Maternal Infant Health Program policy, *Medicaid Provider Manual*
2. MIHP/Medicaid Health Plan Care Coordination Agreement, *MIHP website*
3. MIHP Medicaid Health Plans Frequently Asked Questions, *MIHP website*
4. MHP Points of Contact for MIHP Providers, *MIHP website*

### **Medicaid Health Plan-MIHP Contractual Agreements**

MIHP providers must establish and maintain contractual agreements with the Medicaid Health Plans (MHPs) in their service area to receive payment for in-network services provided to MHP enrollees unless the MHP indicates otherwise.

Contracts are directly negotiated between the MHP and MIHP agency. See the *MIHP-MHP Contacts* list at the MIHP website to determine where to direct inquiries about contracting with the MHPs. This list also provides contact information for the MIHP Care Coordination Liaison and for the billing issues contact at each MHP.

MHPs are not required to contract with all of the MIHP providers operating within their service area. MHPs will determine which MIHP providers they will contract based on several factors including service

area, quality, responsiveness, specialty and network adequacy. Volume may be one consideration but it is not the only consideration.

### **Medicaid Health Plan-MIHP Care Coordination Agreements**

Care Coordination Agreements (CCAs) are separate from contractual agreements. MIHP providers and Medicaid Health Plans (MHPs) must establish and maintain a Care Coordination Agreement (CCA) for both in-network and out-of-network services. The intent of the CCA is to explicitly describe the services to be coordinated and the essential aspects of collaboration between the MHP and the MIHP provider. MIHP providers are encouraged to establish Care Coordination Agreements (CCAs) with all MHPs in their service area, although an MHP is not required to establish a CCA with all MIHP providers. Contact your MHP contract/provider services liaison if you have any questions about or need assistance in obtaining or updating a CCA.

### **Out-of-Network (non-contracted) MIHP Providers**

MIHP services for Fee-For-Service (FFS) beneficiaries are reimbursed through CHAMPS. An MIHP that provides services to a FFS beneficiary may continue to provide services after the beneficiary enrolls in a Medicaid Health Plan (MHP). The MHP is required to reimburse the MIHP until case closure, even if the MHP does not have a contract with the MIHP.

Non-contracted MIHP providers, including those who have a current MIHP relationship with a pregnant woman or infant, are required to contact the enrollee's MHP to discuss operational details before providing out-of-network services. Relationships established during previous pregnancies with out-of-network MIHP providers are not required to be covered by the MHP.

If an MIHP is serving a beneficiary who switches to a different MHP, and the MIHP does not have a contract with the new MHP, the MIHP may be able to continue to see the beneficiary, but must contact the new MHP before providing any additional services. MIHPs must not encourage a beneficiary to switch to a different MHP that has a contract with the MIHP. The MIHP can tell a beneficiary which MHPs they have contracts with, and inform them that if they want to change MHPs, they should call Michigan Enrolls. MIHPs and MHPs should not give enrollment advice to beneficiaries.

It is incumbent upon MIHP providers to check eligibility and MHP enrollment prior to every visit.

### **Medicaid Health Plan Referrals to MIHP**

Within one month of when the Medicaid Health Plan (MHP) determines a pregnant woman or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS-approved, equivalent evidence-based home visiting program that provides pregnancy-related or infant support services. This may be evidenced by enrollee self-attestation. MHPs may be required to present MDHHS evidence of MIHP referral and care coordination, evidence of participation in an equivalent evidence-based home visiting program, or refusal of MIHP services upon request.

MIHP services are voluntary and participants must be allowed the freedom of choice of MIHP providers, including the opportunity to: select an in-network provider; maintain a current service relationship which extends to the infant by the same provider who rendered maternal services; change providers within the MHP network of providers; or decline services.

### Medicaid Health Plan Prior Authorization of Services Not Required in Most Situations

Medicaid Health Plans (MHPs) may not require prior authorization for the Initial Risk Assessment visit, professional visits, drug-exposed infant visits, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in Medicaid policy. MIHP services in excess of limits established in policy may be subject to prior authorization requirements.

Notify the MHP about contacts with MHP enrollees in the following situations:

- a. When you are serving a FFS beneficiary and she subsequently is enrolled in a MHP, send the *MIHP Prenatal or Infant Care Communication* form to notify the MHP contact that she is participating in your MIHP. At that time, initiate contact with the MHP to inquire about entering into a CCA if your MIHP agency does not have a current contract or CCA with the MHP.
- b. When you are doing outreach (not on a MHP referral) and you encounter a beneficiary who is in an MHP to which you are contracted, enroll her in your MIHP and send the *MIHP Prenatal or Infant Care Communication* form to notify the MHP that she is participating in your MIHP.
- c. When you are doing outreach (not on a MHP referral) and you encounter a beneficiary who is in an MHP to which you are non-contracted, tell her to contact her MHP to be referred to an in-network MIHP.
- d. The MIHP is required to notify the MHP that their member has been discharged using the *MIHP Notice of Beneficiary Discharge* within 14 calendar days of entering the *Discharge Summary* into the MIHP database.

You do not need a signed *Consent to Release PHI* in order to share information with the beneficiary's MHP. MDHHS legal counsel has determined that your communications with the MHP are covered under the HIPAA exemption for payment, treatment and operations. MHPs have the right to see the beneficiary's entire MIHP record.

As with all Medicaid-enrolled providers, MIHP providers are able to define the service area that best accommodates their professional operations. MHPs, however, operate in their approved Prosperity Regions.

### Medicaid Health Plans Required to Meet with MIHPs

Medicaid Health Plans (MHPs) are required, per their contracts with the State of Michigan, to meet with MIHPs on a quarterly basis. These meetings are not mandatory for MIHPs, but MIHPs are strongly encouraged to participate.

MHPs work to minimize the number of meetings with MIHPs by coordinating and planning these meetings as collaboratively as possible. The MHP-MIHP collaborative sessions that have been facilitated by MDHHS count toward meeting the quarterly requirement.

### MI Health Link Integrated Care Organizations

MI Health Link is a joint Medicare and Medicaid demonstration designed to integrate care for individuals in Michigan who have both Medicare and Medicaid. Beneficiaries participating in MI Health Link receive both Medicare and Medicaid coverage, including Part D prescription drugs, through new managed care entities called **Integrated Care Organizations (ICOs)**. ICOs partner with existing Pre-paid Inpatient Health Plans (PIHPs) to serve individuals who receive Medicare and Medicaid-funded behavioral health services.

Most persons under the age of 65 must receive Social Security Disability benefits for 24 months in order to qualify for Medicare. This means that they have disabling physical and/or mental health impairments. Persons who have Medicare and Medicaid coverage generally require a high level of care coordination.

MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designated to meet individual needs. ICOs give providers information and resources to support care coordination through timely communication across care team members and through the use of an interoperable electronic platform called the Care Bridge.

- *Assessments*: ICOs will conduct an initial assessment to identify enrollees' needs and make referrals to specialized service providers.
- *[Integrated Care Teams \(ICTs\)](#)*: An ICT, led by the ICO Care Coordinator, will be offered to the enrollee. The team will help manage and coordinate care by participating in the person-centered planning process. Membership will include the enrollee and the enrollee's chosen allies, primary care physician and, as applicable, Long Term Services and Supports (LTSS) Coordinator and PIHP Supports Coordinator. The enrollee and team may also include other providers who are needed.
- *Integrated Individualized Care and Supports Plan (IICSP)*: Through the assessment and the person-centered planning process, the IICSP will be developed with the enrollees and the ICT to identify the supports and services that will best help enrollees meet their needs and care goals. ICT members will provide timely access to care and services identified in the plan and communicate plan facilitation through the Care Bridge.
- *ICO Care Coordinators*: Each enrollee will have Care Coordinators to facilitate communication among the enrollee's providers, including physicians, long term supports and services providers and behavioral health providers. They will also help connect enrollees to other community-based social services to help them live as independently as possible.

In general, individuals who meet all of the following criteria will be eligible to enroll in an ICO:

1. Reside in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, or any county in the Upper Peninsula
2. Are age 21 or older
3. Have full Medicare and full Medicaid benefits
4. Are not enrolled in hospice

There are approximately 31,000 dual-eligible women of child-bearing age in Michigan, each of whom is potentially eligible for MIHP, should she become pregnant or have an infant. MIHP agencies that serve MI Health Link participants need to contract with each beneficiary's ICO in order to be reimbursed for MIHP services.

On July 1, 2016, MDHHS instituted a new process for beneficiary enrollment in the MI Health Link program. This change has billing implications for MIHP providers serving MI Health Link enrollees. See [L 16-42.pdf](#) for additional information.

MI Health Link is jointly administered by the federal Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS), the Michigan State Medicaid Agency. For additional information: [http://www.michigan.gov/mdch/0,4612,7-132-2945\\_64077---,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2945_64077---,00.html) or see Bulletin MSA 14-57, distribution date December 29, 2014, at [http://www.michigan.gov/documents/mdch/MSA\\_14-57\\_477754\\_7.pdf](http://www.michigan.gov/documents/mdch/MSA_14-57_477754_7.pdf)

Submit MI Health Link questions or billing concerns that are not resolved by the ICO to:

Email: [integratedcare@michigan.gov](mailto:integratedcare@michigan.gov)

Mail: MI Health Link  
Medical Services Administration  
PO Box 30479  
Lansing, MI 48909-7979

### **MIHP Communications with the Medical Care Provider**

An MIHP provider must obtain a signed *MIHP Consent to Release Protected Health Information* from the beneficiary or the beneficiary's caregiver in order to release information to the medical care provider. If your agency is both the medical care provider and the MIHP for a given beneficiary, you still need to obtain a signed *MIHP Consent to Release Protected Health Information*.

If the beneficiary is an infant, you must have the mother's consent to share Maternal Considerations with the infant's medical care provider. Her consent would be documented on the infant's *MIHP Consent to Release Protected Health Information*.

If consent is obtained, the MIHP provider is required to share specified beneficiary information with the medical care provider, to use standardized forms to communicate this information, and to meet specified timeframes in communicating this information.

The MIHP provider uses a standardized form to share beneficiary information at enrollment, whenever there's a significant change in status, and at service closure. The form provides space for the medical care provider to identify issues that he or she would like the MIHP provider to address with the beneficiary. At the request of the medical care provider and with the consent of the beneficiary, the MIHP provider forwards a copy of the beneficiary's *Plan of Care*, which identifies all of the MIHP interventions being implemented by the MIHP team.

If the beneficiary does not consent to share information with her medical care provider, do not send these forms to the medical care provider. However, complete the medical care provider communications form to send to the MHP.

### **When Beneficiary Changes Medical Care Providers**

When a beneficiary or caregiver informs you that she or her infant has a new medical care provider, ask her to update her *MIHP Consent to Release Protected Health Information* by adding the new medical care provider's name and initialing and dating it. After you have obtained her authorization, send the new provider a copy of the initial *MIHP Communication* form with a note explaining that it was originally sent to a previous medical care provider when the beneficiary first enrolled in MIHP. Send subsequent medical care provider communications to the new provider.

### **Obtaining Medical Care Provider Authorization for MIHP Services**

MIHP providers must have authorization from a medical care provider in order to:

1. Provide the services of a registered dietitian
2. Provide an additional 9 infant visits after the initial 9 visits are completed
3. Provide an additional 18 infant visits after the first 18 visits are completed when the beneficiary is a substance-exposed infant

The MIHP has two ways to obtain authorization for these services. The first way is to ask the beneficiary's medical care provider for a physician order. Alternatively, the MIHP may have access to a medical care provider who will issue a standing order covering one or more of the situations listed above. Standing orders are a special case of written physician's orders which are conditioned upon the occurrence of specified events. In the case of MIHP, the events are the identification of the need for RD services, additional infant visits, or substance-exposed infant visits. Standing orders are commonly used in local health department clinics.

Physician orders must include the following elements: printed MIHP agency name; printed medical provider name, address, and phone number; medical provider signature and credentials; (MD, DO, NP, CNM, PA), and date of signature. A standing order written on a medical provider's prescription pad is also acceptable if the elements listed above are included.

The MIHP must maintain all physician orders in the medical record. The reason for and purpose of additional visits must be well documented in the medical record. A copy of the standing order must be placed in the beneficiary's chart when the order goes into effect. Standing orders must be reviewed and signed by the medical care provider annually and the updated order must be placed in the chart. It is acceptable to place the standing order in the chart of every beneficiary, even though it may not actually be needed at any point throughout the course of care.

### **Verbal Orders if There Is an Urgent Concern**

Verbal orders should only be utilized if there is an urgent concern that requires the beneficiary to be seen that same day. In all other cases, the medical care provider should send a written order in response to the MIHP authorization request.

A verbal order may only be taken by the SW or RN. The process is as follows:

1. The RN or SW calls the medical care provider, explains the situation, and requests the verbal order.
2. The medical care provider verbally issues the order over the phone.
3. The RN or SW documents why the extra visits are needed and what the medical care provider stated on the phone on a *Professional Visit Progress Note* or *Contact Log* and faxes it to the medical care provider that same day, requesting the signed order be returned within 48 hours.
4. If the medical care provider does not return the signed order within 48 hours, the RN or SW follows up with the medical provider at least weekly, until the signed order is received. Each follow-up contact must be documented in the chart.
5. If the written order is not received from the medical care provider, the agency cannot bill for the professional visit.

## SECTION 4 - BASIC DESCRIPTION OF MIHP SERVICES

### Types of MIHP Services

MIHP provides case management and education services for maternal/infant dyads. Case Management services are provided by a registered nurse or a licensed social worker. Education services are provided by a registered nurse, a licensed social worker, a registered dietitian, or an infant mental health specialist. MIHP staff providing these services use a supportive approach based on Motivational Interviewing principles.

### MIHP Case Management Services

Case Management Services include:

1. Administration of *Risk Identifier* and completion of *Plan of Care, Part 1* (RN or SW; must be signed by both)
2. Development of *Plan of Care, Parts 2 – 3* (RN and SW; must be signed by both)
3. Implementation of *Plan of Care, Part 2* (two or more of the four disciplines)
4. Documentation of visits (two or more of the four disciplines)
5. Monitoring implementation of *Plan of Care, Part 2* (Case Manager: RN or SW)
6. Coordination with Medicaid Health Plans (Case Manager: RN or SW)
7. Coordination with Medical Care Provider (Case Manager: RN or SW)
8. Conclusion of MIHP services (any one of the four disciplines; only the RN or SW can do the *Discharge Summary*)

The registered nurse or the licensed social worker is designated as the case manager for each beneficiary. The registered dietitian and the infant mental health specialist cannot function as the case manager.

The case manager is responsible for assessment, planning, facilitation, care coordination, evaluation, and monitoring all services provided to the beneficiary, including referrals and follow-up. It is the role of the case manager to advocate for the beneficiary when necessary and ensure that she is involved in her own care plan development and service arrangements to the greatest possible extent. It is the ultimate objective of the provider to empower the beneficiary to successfully navigate the health care system. Detailed information about MIHP services is provided in *Chapter 8 – MIHP Service Delivery*.

### MIHP Education Services

In addition to coordinating the beneficiary's care, the MIHP provider delivers or arranges for the delivery of a variety of education services. Education services are provided as part of the implementation of the *Plan of Care, Parts 1 – 2*. MIHP-reimbursable education activities are described in the grid below:

Education Services Category & Discipline	MIHP-Reimbursable Activities
<b>Health Education</b> Registered Nurse or Licensed Social Worker	Communication of information to improve knowledge of maternal and infant health and to foster the motivation, skills and confidence (self-efficacy) necessary for beneficiaries to take action to improve individual risk factors and risk behaviors, and to navigate the health care system.  Covers: <ul style="list-style-type: none"> <li>• One-on-one/dyad visits only</li> </ul>

Education Services Category & Discipline	MIHP-Reimbursable Activities
<b>Post-Partum Lactation Support and Counseling</b> Registered Nurse or Licensed Social Worker who is an International Board Certified Lactation Consultant (IBCLC)	Provision of individual, comprehensive lactation support and counseling services for post-partum women up to and through 60 days post-delivery. Includes assessment and the following interventions, at a minimum: positioning techniques, proper latch on, frequency of feeding, recognizing hunger cues, expression of milk, how to tell when baby is getting enough, and when to call a health care professional.  Covers: <ul style="list-style-type: none"> <li>One-on-one/dyad visits only</li> </ul>
<b>Nutrition Education</b> Registered Nurse or Licensed Social Worker or Registered Dietitian (RD requires physician order)	Communication of basic, general information about nutrition during pregnancy and infancy for beneficiaries who do not have significant nutrition risks or health concerns that are affected by or related to their diet.  Covers: <ul style="list-style-type: none"> <li>One-on-one/dyad visits only</li> </ul>
<b>Service Coordination</b> Licensed Social Worker or Registered Nurse	Provision of psychosocial support, problem-solving assistance, and facilitation of referrals for beneficiaries with risks in the mental health, alcohol misuse, substance misuse, or domestic violence domains. Does NOT include clinical social work practice (i.e., assessment, diagnosis and psychotherapy). Also includes assisting any beneficiary with basic needs.  Covers: <ul style="list-style-type: none"> <li>One-on-one/dyad visits only</li> </ul>
<b>Nutrition Counseling</b> Registered Dietitian  (NOTE: Requires physician order)	Provision of medically-necessary, individualized nutrition counseling for health problems that are affected by or related to diet (e.g., inadequate maternal weight gain, nausea/vomiting, expecting multiple births, eating disorder, fetal growth restriction, hypertension, unhealthy pre-pregnancy weight (over or under), gestational diabetes; pica, etc.; premature infant, infant with eating difficulties, poor infant weight gain/not following growth curve, etc.)  Covers: <ul style="list-style-type: none"> <li>One-on-one/dyad visits only</li> </ul>
<b>Infant Mental Health (IMH) Services</b> IMH Specialist	Provision of home-based, parent-infant intervention where the parent's condition and life circumstances or characteristics of the infant threaten parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The IMH specialist may: <ol style="list-style-type: none"> <li>Assess need for infant mental health services, using recommended objective tools that measure: infant social-emotional development (Ages and Stages Questionnaires: Social/Emotional-2, Devereux Infant-Toddler Assessment); parent-infant attachment (Massie/Campbell Scale of Mother Infant Attachment during Stress); and parental depression (Edinburgh Postnatal Depression Scale).</li> </ol>

Education Services Category & Discipline	MIHP-Reimbursable Activities
	<ol style="list-style-type: none"> <li>2. If assessed need is low-moderate, provide brief, direct parent-infant intervention and/or referral to other parenting support program.</li> <li>3. If assessed need is high, encourage beneficiary to accept referral to Community Mental Health Services Program (CMHSP) or other mental health provider for clinical infant mental health services; facilitate referral; support beneficiary to follow through with treatment. If beneficiary refuses referral, provide support with goal of getting her to accept treatment, and provide brief, direct parent-infant intervention.</li> </ol> <p>Covers:</p> <ul style="list-style-type: none"> <li>• One-on-one/dyad visits only</li> </ul>
<b>Childbirth Education Group Classes (CBE)</b>	Provision of group classes to prepare first-time mothers for the experience of childbirth, using a curriculum covering topics specified by Medicaid. Topics include, but are not limited to, the following: pregnancy; labor and delivery; infant care and feeding; postpartum care; and family planning. The curriculum is relevant for all first-time mothers, regardless of risk level in any particular MIHP domain. (See <i>Medicaid Provider Manual Chapter, MIHP, Section 2.11 Childbirth Education</i> ).
<b>Parenting Education Group Classes (PE)</b>	Provision of group classes to develop positive parenting skills and attitudes and facilitate interaction among parents, using a curriculum covering topics specified by Medicaid. Topics include, but are not limited to the following: feeding; elimination; illness; injuries; patterns of sleep, rest, activity and crying; hygiene; developmental milestones; emotional needs; toxic and/or hazardous waste; immunizations; and day-to-day living with children. The curriculum is relevant for all parents, regardless of risk level in any particular MIHP domain. (See <i>Medicaid Provider Manual Chapter, MIHP, Section 2.12 Parenting Education</i> ).

All MIHP professionals must function within their scope of practice.

## Staffing

### Required and Optional Staff

The MIHP provider is required to provide the services of a registered nurse and a licensed social worker. At least one of these two required disciplines must be employed by the provider, but the other discipline may be contracted through another agency.

The provider is not required to provide the services of a registered dietitian or infant mental health specialist. However, MIHP beneficiaries must have access to the services of all four disciplines, as needed.

The provider may choose to directly provide nutrition counseling and infant mental health services (i.e., have a registered dietitian and infant mental health specialist on staff), to contract with an individual or

another agency for these services, or to refer beneficiaries to other local agencies that offer these services. If the MIHP provider opts to directly provide nutritional counseling and infant mental health services, the provider may hire or contract with qualified professionals and bill Medicaid for these services.

If the MIHP provider chooses not to provide nutrition counseling services directly, they must refer a beneficiary who needs an RD to another provider (e.g., WIC, MHP, local hospital, local health department, or community health center) that has the capacity to provide high-risk nutrition counseling services. If the MIHP provider chooses not to provide infant mental health services directly, they must refer a beneficiary who needs an IMHS to another provider (e.g., Community Mental Health or other infant mental health provider).

The provider may provide post-partum lactation support counseling services if there is an RN or SW on the *MIHP Personnel Roster* who has been certified by the IBCLC. If the provider chooses not to offer IBCLC services directly, they are encouraged to refer a beneficiary who needs breastfeeding support to breastfeeding resources in the community.

### **Both Required Disciplines Must Regularly Conduct Visits**

Both required disciplines must regularly conduct professional visits. Both required disciplines must conduct at least one visit with each beneficiary during the course of service. If both disciplines do not conduct at least one visit, the reason must be documented in the chart, e.g., the beneficiary declined the visit with the other required discipline; it was decided that just one discipline would see the beneficiary to build trust with a wary beneficiary, etc.

Aside from the required RN visit and the required SW visit, the remaining visits should be conducted by the MIHP discipline or disciplines whose expertise is most relevant to the particular beneficiary, based on her unique health risks, strengths and goals.

### **Minimum Staffing Requirement**

At a minimum, the MIHP staff must include the MIHP program coordinator, one registered nurse (RN), and one licensed social worker (LLBSW, LLMSW, LBSW, or LMSW). The coordinator may also serve as an RN, SW, RD, or IMHS.

Staffing must be sufficient to meet the needs of beneficiaries. New providers must have proof that they have at least one registered nurse and one licensed social worker on staff before they can begin to provide MIHP services.

MDHHS expects that all MIHP agencies maintain the staffing capacity to provide quality services. This means that the staffing level must be sufficient to ensure that each beneficiary can be seen at least monthly (once in any given month).

### **Back-up Staffing Plan**

In their agency staffing protocol, providers must describe a back-up staffing plan that would be activated whenever the MIHP is void of one of the required disciplines (RN or SW) for either one of the following reasons:

1. RN or SW takes a planned leave of two to six weeks duration (e.g., vacation, maternity leave, etc.) and intends to return to work. In this situation, the agency must have a back-up plan for a beneficiary to access the services of the missing discipline in an emergency situation.
2. RN or SW leaves the agency and the agency needs to hire a replacement. Providers must notify their consultant within 5 business days via email whenever they do not have at least one nurse and one social worker on staff for more than six consecutive weeks. At that time, the MIHP consultant will discuss the actual implementation of the plan with the provider. The consultant will reply in writing, confirming that notification was received. This documentation from the consultant must be shown to the reviewer at the certification review.

If the MIHP is void of one of the required disciplines due to a staff vacancy, it must be for a period of less than 3 months and the MIHP provider's back-up staffing plan must be implemented throughout the entire hiring process. If the vacant position is not filled within 3 months, no back-up staffing plan has been implemented, and ongoing communication with the consultant is not being maintained, the MIHP may be decertified.

The back-up plan must be implemented on the date that the RN or SW leaves the agency. The length of time that an MIHP agency may operate with "back-up" staff is at the discretion of MDHHS. Ongoing contact must be maintained with the consultant during this period.

The back-up staffing plan must specifically indicate how the agency will assure that beneficiaries will have access to critical services when the agency is temporarily void of one of the disciplines. Back-up staffing generally is done in one of the following ways:

The agency identifies an RN or SW who agrees to provide MIHP services during the course of the hiring process. This individual completes MIHP new employee training, presents proof of licensure, signs a confidentiality agreement, and is listed on the MIHP Personnel Roster. The MIHP may bill for MIHP services provided by this individual.

- a. The agency makes an agreement with another MIHP that will "lend" an RN or SW to the first agency, if needed.
- b. In rare, extenuating circumstances, options other than "a" and "b" above may be approved at the discretion of MDHHS. Contact your consultant to discuss alternative options.

You are not required to update the back-up staffing plan annually, however, you are encouraged to review the plan to ensure it remains applicable and current.

### **Nutrition Education and Nutrition Counseling**

It is important to distinguish between nutrition education and nutrition counseling:

**Nutrition education** is the communication of basic, general information about nutrition during pregnancy and infancy for beneficiaries who do not have significant nutrition risks or health concerns that are affected by diet. This includes beneficiaries who score low risk on the *Risk Identifier* maternal or infant nutrition domain. Nutrition education may be provided by the registered nurse, licensed social worker, or registered dietitian.

**Nutrition counseling** is the provision of medically-necessary, individualized counseling for health problems that are affected by or related to diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, etc.; infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.). Nutrition counseling may be provided only by a registered dietitian. When a high maternal nutrition risk or a high infant nutrition risk is identified, nutrition counseling services must be provided by an RD or there must be documentation that a referral was offered or made, as documented on a *Professional Visit Progress Note*.

The MIHP must provide nutrition counseling or make the necessary arrangements for nutrition counseling. Nutrition counseling may be available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the beneficiary's MHP, or a local hospital, health department, or community health center, etc.

The documentation in the chart must clearly identify the entity that is providing nutrition counseling services. If the provider opts to refer beneficiaries to other agencies that offer these services, the MIHP provider cannot bill for services provided by these other agencies.

### **Obtaining a Physician Order for RD Services**

Because dietitians are not licensed in Michigan, a physician order must be obtained before an RD can provide services to a MIHP beneficiary, as specified below:

The MIHP provider may have access to a medical care provider who will issue a standing order to cover a MIHP beneficiary needing the services of a registered dietitian (RD) because of health problems that are affected by diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.). The standing order can state that it applies to the MIHP beneficiary who has nutrition needs requiring the services of an RD. If a beneficiary is seen by an RD pursuant to a standing order, a copy of the standing order must be placed in the beneficiary's chart. Standing orders must be reviewed and reauthorized annually.

If the MIHP provider does not have access to a medical care provider who will issue a standing order, the provider must obtain an order from the beneficiary's medical care provider (e.g., physician, physician assistant, nurse midwife, pediatric nurse practitioner, family nurse practitioner, or Medicaid Health Plan) before arranging for nutrition counseling services by an RD.

Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 3 – MIHP Goal and Primary Partners*.

With a physician order, the RD may visit a beneficiary, even if a nutritional risk was not identified through the *Maternal or Infant Risk Identifier*. In this case, the RD would document the need for the visit (e.g., beneficiary requests nutrition education or counseling). Any visit by an RD with a physician order in place and a nutritional need identified, although possibly a minor need, is billable and payable. While in the home addressing nutritional needs, the RD may touch on other domains (e.g., family planning).

In order to bill for a visit made by the RD, the agency must have:

1. A physician order for an RD visit
2. List the RD on the *MIHP Personnel Roster*
3. A completed *Risk Identifier* and signed *Plan of Care*
4. The RD document the visit in the beneficiary's chart on a *Professional Visit Progress Note*

### **Infant Mental Health Services**

Infant mental health services may be needed for purposes of implementing a beneficiary's *Plan of Care*. Infant mental health services are available through Community Mental Health Services Programs (CMHSPs) for families who need intensive parent-infant intervention. In the CMHSP system, these services are referred to as Medicaid home-based services for infants and toddlers.

However, some beneficiaries who need infant mental health services may not meet CMHSP criteria for intensive home-based services. If infant mental health services are not available through other agencies in the local area, the MIHP provider is encouraged to explore the feasibility of hiring an infant mental health specialist. Infant mental health specialists must meet the qualifications specified in the *Medicaid Policy Manual*, including licensure by the State of Michigan and endorsement by the Michigan Association for Infant Mental Health. MDHHS MIHP encourages you to explore hiring an IMH specialist.

It is perfectly acceptable for a beneficiary to receive MIHP services and infant mental health services concurrently. Infant mental health services can continue after the infant ages out of MIHP.

### **MIHP Program Coordinator Role and Qualifications**

The MIHP program coordinator is responsible for oversight of all aspects of the program. The following is a position description for the MIHP program coordinator which was developed with the assistance of MIHP providers across the state:

#### **Role of MIHP Program Coordinator:**

To implement the Maternal Infant Health Program in compliance with Medicaid requirements and fidelity to the model, in order to provide high-quality home visiting services that promote healthy pregnancies, positive birth outcomes, and infant health and development.

#### **Duties and Responsibilities**

1. Write, update, and enforce internal policies and protocols that comply with Medicaid requirements
2. Coordinate the program: develop and/or monitor contracts, produce reports, manage crisis situations
3. Oversee professional billing process and coordinate with internal billing department
4. Provide and coordinate professional development activities for staff, including orientation and training
5. Supervise staff
6. Facilitate case consultation across disciplines
7. Monitor and coordinate staff workloads
8. Develop and maintain updated list of community resources for use by staff and beneficiaries
9. Conduct and coordinate program outreach and marketing activities
10. Communicate and collaborate with other community agencies, including other MIHPs; represent MIHP on local/regional coalitions and governing bodies

11. Communicate with Medicaid Health Plans and medical care providers
12. Oversee and monitor referral, intake and follow-up
13. Prepare for certification reviews and submit Corrective Action Plans, as required
14. Implement continuous quality improvement: conduct chart reviews, productivity analyses, consumer satisfaction analyses, and analyses of MDHHS data reports; implement quality improvement strategies based on the findings
15. May provide direct services; conduct home visits, carry a caseload
16. Ensure entry of MIHP data into the MDHHS database
17. Review and interpret reports; share with staff and partners, as appropriate
18. Ensure that beneficiaries are being appropriately served

### **Qualifications**

Bachelor's degree preferred.

### **Experience**

Experience coordinating or managing a health or human services related program or project.

### **Skills and Knowledge**

- Ability to implement a program in compliance with required policies and procedures
- Quality improvement process skills
- Leadership and supervision skills
- Ability to organize and coordinate the work of others
- Effective written and verbal communication and interpersonal skills
- Training skills
- Computer skills
- Ability to problem-solve
- Ability to follow through and follow up
- Ability to multi-task
- Detail-oriented
- Flexible

### **Professional Staff Qualifications**

MIHP SW staff qualifications were revised effective May 1, 2016. While licensure is still required, a social work degree is no longer specified for social workers. This means social workers, who were “grandfathered in” in Michigan in 2005 when licensure was established, are qualified to provide MIHP services. Although they do not have social work degrees, they have degrees in related fields, such as counseling or psychology. Qualifications for the MIHP RN, SW, RD, IBCLC, and IMHS are detailed in Medicaid policy.

To qualify as an MIHP Infant Mental Health Specialist, an individual must have all of the following qualifications listed below:

- Licensure by the State of Michigan (as a psychologist, master social worker or professional counselor)
- A degree as a psychologist, master social worker, or professional counselor
- Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH) as an Infant Family Specialist (II) or Infant Mental Health Specialist (III).
- At least one year of experience in an infant health program

A professional who meets the qualification requirements for more than one MIHP discipline (e.g., social work and infant mental health) may provide both services for MIHP beneficiaries. However, only one billable visit is allowed per beneficiary per day.

### Licensure and Verification

It is the responsibility of the MIHP provider to maintain proof of current registration, licensure and certification for all professionals providing services on behalf of the agency. Professional staff must have one or more of the following registrations, licenses, or certifications in order to provide MIHP services:

RN	Licensed Registered Nurse
LLBSW	Limited Licensed Bachelor's Social Worker
LLMSW	Limited Licensed Master's Social Worker
LBSW	Licensed Bachelor's Social Worker
LMSW	Licensed Master's Social Worker
IBCLC	International Board Certified Lactation Consultant (also must be a licensed RN or SW in order to bill for MIHP lactation support and counseling services)

Michigan professional licenses may be verified by the Department of Licensing and Regulatory Affairs (LARA).

There should be a copy of each of the following in the personnel file of every MIHP professional on staff:

- Current license, registration and certification
- Verification of current license, registration and certification
- Resume

The MIHP coordinator must carefully track the license, registration and certification expiration dates for all professional staff. A professional with an expired credential must not provide any MIHP services as of the date of expiration. Per Medicaid policy, services provided by a professional with an expired credential will not be reimbursed.

### MIHP Personnel Roster

Providers must assure that professional staff are qualified to provide MIHP services. Providers must use the *MIHP Agency Personnel Roster* to document specific information about the qualifications of each person on the MIHP staff, including everyone authorized to use the State of Michigan MILogin System for purposes of entering MIHP data into the MDHHS database.

The *Personnel Roster* must be updated and submitted to MDHHS (even if there are no updates) within 30 days after the end of every quarter (quarters end on Dec. 31, March 31, June 30, and Sept. 30). It is your responsibility to submit each *Personnel Roster* during the month after the end of the quarter; MDHHS does not issue reminders every quarter.

#### MIHP Personnel Roster Due Dates

Quarter	Personnel Roster Due Date
1 <sup>st</sup> Quarter: October 1 - December 31	January 1 – 30
2 <sup>nd</sup> Quarter: January 1 – March 31	April 1 – 30
3 <sup>rd</sup> Quarter: April 1 – June 30	July 1 – 30
4 <sup>th</sup> Quarter: July 1 – September 30	October 1 – 30

MIHP providers are required to submit an updated *Personnel Roster* to authorize a new staff member to use the MILogin System or to deactivate a user when a staff member leaves prior to the end of the quarter. This must be done within 10 business days of any agency personnel change.

If you have made any changes to your agency's contact information (address, phone number, fax number, etc.) on the *Personnel Roster*, please indicate this in the body of your *Personnel Roster* submission email.

If the agency provides childbirth education classes, the instructor does not have to be listed on the *Personnel Roster*, if not providing any other MIHP services.

### **Staffing Waiver Requests**

At times, a provider may be unable to find a fully qualified licensed RN or SW to fill a particular position. In this case, the provider can request that certain personnel requirements be waived. Education and licensing/registration/endorsement requirements cannot be waived, but requirements for having a specified amount of maternal and child health experience could possibly be waived, depending on the situation. Time spent doing an internship related to an academic course of study does not count toward the year of professional expertise required by Medicaid. MDHHS does not grant waivers for registered dietitians, infant mental health specialists, or International Board Certified Lactation Consultants. A provider who is unable to find a licensed RN or SW who fully meets staffing requirements must submit a waiver application in writing to MDHHS, explaining why a waiver is being requested and stating that the provider will assure that the appropriate in-service training will be provided for the individual in question. MDHHS examines the validity of each waiver request and approves or disapproves accordingly within three business days of receipt of an accurate and complete request.

Providers who wish to submit a waiver application should go to the MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp) and click "Providers" and then "Current MIHP Providers" to obtain the following documents:

1. Professional Staff Waiver Application Instructions
2. Required Training for New and Waiver Professional Staff
3. Professional Staff Waiver Training Matrix
4. Topics Relevant to MIHP Practice
5. Social Determinants and Contributing Factors for Infant Mortality
6. Health Disparities and Social Justice List of Definitions
7. Notice of New Professional Staff Training Completion
8. Notice of Staff Waiver Completion

The waiver application must be approved by MDHHS prior to MIHP employment. Waiver staff must complete professional development activities beyond those required for all new staff, including a minimum of six beneficiary visits conducted jointly with experienced MIHP staff. Waiver staff must be mentored by a professional who practices the same discipline to ensure that the waiver staff is learning about the role of their own discipline in the program. In other words, a nurse must be mentored by another nurse and a social worker must be mentored by another social worker. However, this does not prohibit the waiver staff from shadowing staff who practice other disciplines during the training period. MIHP program coordinators are encouraged to involve other disciplines in training so the waiver staff has an understanding of the roles of the other professionals in the beneficiary's overall care.

Waiver staff training must be completed within six months of the date that an individual begins employment as an MIHP professional staff. The *Notice of Waiver Completion* must be maintained in the individual's personnel file. It must also be sent to MDHHS. Visits provided by an unqualified staff who has not obtained a waiver are not billable.

### **Staff Supervision**

MDHHS strongly encourages MIHP agencies to provide reflective supervision for MIHP professional staff. The Michigan Association for Infant Mental Health has developed *Best Practice Guidelines for Reflective Supervision/Consultation*. These guidelines, which distinguish between administrative, clinical and reflective supervision, are excerpted below. Additional information may be found at [www.mi-aimh.org](http://www.mi-aimh.org).

### **Best Practice for Reflective Supervision/Consultation Guidelines**

The intent of these guidelines is to emphasize the importance of reflective supervision and consultation for best practice and to better assure that those providing reflective supervision and consultation are appropriately trained.

#### **Distinguishing Between Administrative Supervision, Clinical Supervision and Reflective Supervision/Consultation**

Supervisors of infant and family programs are generally required to provide administrative and/or clinical supervision, while reflective supervision may be optional. Reflective supervision is a time to reflect on professional practices (i.e., the home visitor to reflect verbally with supervisor). Administrative elements are not to be a part of reflective supervision.

Administrative supervision relates to the oversight of federal, state and agency regulations, program policies, rules and procedures. Supervision that is primarily administrative will involve the following objectives:

- Hire
- Train/educate
- Oversee paperwork
- Write reports
- Explain rules and policies
- Coordinate
- Monitor productivity
- Evaluate

Clinical supervision/consultation, while case-focused, does not necessarily consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/toddler and family. Supervision or consultation that is primarily clinical will most likely include many or all of the administrative content that are listed above, as well as the following:

- Review casework
- Discuss the diagnostic impressions and diagnosis
- Discuss intervention strategies related to the intervention
- Review the intervention or treatment plan
- Review and evaluate clinical progress
- Give guidance/advice
- Teach

Reflective supervision/consultation goes beyond clinical supervision to shared exploration of the parallel process, i.e., attention to all of the relationships, including that between practitioner and parent, between parent and infant/toddler, and between practitioner and supervisor. It is critical to understand how each of these relationships affects the others. Of additional importance, by attending to the emotional content of the work and how reactions to the content affect the work, reflective supervision/consultation relates to professional and personal development within one's discipline. Finally, there is often greater emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor/consultant. The components of reflective supervision/consultation include:

- Form a trusting relationship between supervisor and practitioner
- Establish consistent and predictable meetings and times
- Ask questions that encourage details about the infant, parent and emerging relationship
- Listen
- Remain emotionally present
- Teach/guide
- Nurture/support
- Integrate emotion and reason
- Foster the reflective process to be internalized by the supervisee
- Explore the parallel process and allow time for personal reflection
- Attend to how reactions to the content affect the reflective process

### **Sex-Offender Registry Check**

The MIHP provider may wish to check the Michigan State Police Sex-Offender Registry before making an offer of employment to an individual who will work directly with MIHP beneficiaries. The registry is available at <http://www.mipsor.state.mi.us>. The provider may also wish to do a criminal history check using the Michigan Department of State Police's internet criminal history access tool (ICHAT) at <http://apps.michigan.gov/ICHAT/Home.aspx>.

### **Required Identification Badges for MIHP Direct Service Staff**

MIHP staff persons who work directly with beneficiaries in their homes or at other community locations must carry identification (ID) badges with them at all times. This is to assure beneficiaries that staff are legitimately affiliated with the MIHP. The ID badge must be presented when meeting a beneficiary for the first time and whenever a beneficiary asks to see it. It is not sufficient to use a business card as a badge.

An ID badge must include a picture of the staff person, the staff person's name, the program name, the phrase "Maternal Infant Health Program (MIHP)" if it is not included in the program name, and the name of the agency, if applicable. However, agencies that are part of a local health department, FQHC, hospital system, or home health agency that issues identification badges to all of its employees are not required to alter their badges to include "MIHP."

## Eligibility and Duration of MIHP Services for the Mother-Infant Dyad

MIHP services are a Medicaid-only benefit. As a Medicaid beneficiary, individuals enrolled in Fee-for-Service, a Medicaid health plan or in one of the following programs may be eligible to receive MIHP services:

- Healthy Kids for Pregnant Women and Children
- Group 2 Pregnant Women Program
- U-19
- MICHild
- The Healthy Michigan Plan
- Maternal Outpatient Medical Services (MOMS)

### Maternal MIHP Eligibility

#### Healthy Kids for Pregnant Women

Under the Healthy Kids for Pregnant Women program, a woman is eligible for Medicaid throughout her pregnancy, the month her pregnancy ends, and for two calendar months following the month her pregnancy ends (*Bridges Eligibility Manual, Michigan MDHHS*). For example, if she gives birth on any day in September, she remains eligible through November. Once the beneficiary delivers her baby, she should be encouraged to see her medical care provider for her postpartum visit while her Medicaid coverage is still in effect.

If the local Michigan Department of Health and Human Services (MDHHS) office terminates Medicaid coverage for the pregnant woman earlier than two full months after the birth month, contact her MDHHS worker to determine the reason. If the reason does not appear to be in keeping with Medicaid policy, contact your consultant.

#### Group 2 Pregnant Women Program

The spend-down requirement for Medicaid beneficiaries in the Group 2 Pregnant Women Program (spend-down waived for pregnant women) is typically met after the first prenatal visit. If there are questions regarding spend-down requirements, the beneficiary is advised to consult her MDHHS caseworker.

#### U-19

U-19 is a Medicaid health care program for low-income children under age 19. There is only an income test. There is no monthly premium for this Medicaid program. Most children who are eligible for U-19 Medicaid are enrolled in a Medicaid Health Plan. This program provides a comprehensive package of health care benefits including vision, dental, and mental health services. Contact the [local MDHHS office in your county](#) to apply for this program or apply online at [www.michigan.gov/mibridges](http://www.michigan.gov/mibridges).

#### MICHild

MICHild is a health care program for low income and uninsured children of Michigan's working families. This program is for children under age 19. MICHild has a higher income limit than U-19 Medicaid. There is only an income test. There is a \$10 per family monthly premium for MICHild. The \$10 monthly premium is for all of the children in one family. The child must be enrolled in a MICHild health and dental plan in order to receive services. Beneficiaries receive a comprehensive package of health care benefits including vision, dental, and mental health services. For more information and to apply, contact MICHild at 1-888-988-6300 or visit the MICHild Information website at [www.michigan.gov/michild](http://www.michigan.gov/michild). (If a MICHild beneficiary becomes pregnant, she may remain in MICHild and she is eligible for MIHP.)

### Healthy Michigan Plan

A woman may not be pregnant at the time of application to the Healthy Michigan Plan. If she applies while pregnant, she will be referred to Healthy Kids for Pregnant Women. However, if she becomes pregnant while enrolled in the Healthy Michigan Plan, she may choose to remain in the Plan or switch to Healthy Kids for Pregnant Women during her pregnancy.

### Maternity Outpatient Medical Services (MOMS) Beneficiaries Eligible for Prenatal MIHP Services Only

Women in the MOMS program are eligible for MIHP, but only during the prenatal period. MIHP providers will not receive reimbursement for postpartum visits to women in the MOMS program. Postpartum care provided in the MOMS program is limited to family planning services and medically necessary ambulatory services. However, at birth, the infant becomes eligible for MIHP and the dyad/family may continue to receive MIHP services.

### Infant MIHP Eligibility and Age Limit

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. After the infant is born, the MIHP provider must observe the infant during every visit with the primary caregiver (i.e., mother, father, foster parent etc.).

Infants are eligible for MIHP from birth to 12 months of age, as long as they are covered by Medicaid.

MIHP was specifically designed to serve infants from birth to 12 months of age. The *Infant Risk Identifier* and infant interventions were not intended to meet the developmental needs of toddlers. Infants 12 months of age or older should not be enrolled in MIHP. However, when on a rare occasion, an MIHP encounters a child 12 months or older who is in a situation that warrants an exception to this requirement, the MIHP must submit a statement in writing to their consultant requesting approval to enroll the infant. If the consultant approves the request, the MIHP will receive authorization in writing. Authorization from the MIHP consultant must be maintained in the beneficiary's medical record along with documentation of how the beneficiary is benefitting from MIHP services.

When an infant being served by MIHP reaches 12 months of age, you should begin transition planning and attempt to find a more age-appropriate program for the infant. If the infant reaches the age of 18 months and continues to be served by your MIHP, you are required to submit a written request for approval to your consultant to allow you to continue serving the beneficiary. If the MIHP consultant approves, the MIHP provider will receive authorization in writing. Documentation of authorization from the MIHP consultant must be maintained in the beneficiary record.

### MIHP Enrollment Period

Ideally, MIHP serves the mother-infant dyad from early in the pregnancy, through the postpartum period, and throughout infancy, to the extent of maximizing authorized visits to meet *Plan of Care* objectives. However, a Medicaid-eligible pregnant woman may enroll in MIHP at any point during her pregnancy and a Medicaid-eligible infant may be enrolled in MIHP at any point during infancy up to 12 months of age.

MIHP services may be provided for a woman with a positive home pregnancy test before her pregnancy has been confirmed by a doctor. However, the provider should help her access a medical care provider for confirmation of the pregnancy as soon as possible.

### Consultant Approval Required to Serve Beneficiaries in Three Special Situations

Consultant approval is required to serve FFS and MHP beneficiaries in the following situations:

1. Risk Identifier indicates no scored risks for beneficiary. The *MIHP Risk Identifier* does not indicate scored risks for MIHP services, yet professional observation suggests MIHP services are indicated.
2. Infant is older than 12 months at time of MIHP enrollment. *MIHP Risk Identifiers* and educational materials are designed for use with infants, but the consultant may approve enrolling a child over 12 months of age under special circumstances.
3. Infant reaches the age of 18 months while enrolled in the MIHP. MIHP is not intended to serve toddlers, but the consultant may approve serving a child over 18 months of age under special circumstances.

To request permission to enroll a FFS or MHP beneficiary with no scored risks, or to enroll an infant over the age of 12 months, or to continue to serve an infant who reaches 18 months of age, contact your consultant to request prior approval. If your request is approved, the consultant will respond to you in writing. File the written approval in the beneficiary's chart, and document the approval on the *MIHP-MHP Communication Tool*.

### Primary Caregiver Definition

Most often, the primary caregiver of an infant enrolled in MIHP is the infant's mother. However, if the mother is not functioning as the primary caregiver, the MIHP provider may visit with another individual who is serving in that capacity, such as the father, grandmother, aunt, other relative, or foster parent.

Primary caregiver is defined as the parent or non-parent who has the greatest responsibility for the daily care of the infant. If the primary caregiver has a job or attends school, the provider must accommodate her schedule, rather than conduct home visits with another person who provides child care while the mother is at work or school.

In some situations, the mother or parent may designate someone else as primary caregiver. For example, if the mother works all day, the mother may identify the grandmother as the primary caregiver at the time of the *Risk Identifier* visit. If the mother says that the grandmother is the primary caregiver, the *Risk Identifier* is still done with the mother, but infant visits are conducted with the grandmother.

### Infant in Foster Care

If an infant who was previously open to MIHP while living with his biological mother is placed in foster care and the foster parent wants MIHP services to continue, it is acceptable to serve the infant and foster parent. In this case, you obtain signed consents (to participate in MIHP and to release PHI) from the foster parent and continue to implement the infant's *POC 2*. If a new issue is identified with the infant, add the appropriate domain to the *POC 2*. If a Maternal Consideration surfaces with the foster parent, add the appropriate domain to the *POC 2*.

If an infant is in foster care at the time of MIHP enrollment, administer the *Infant Risk Identifier* with the foster parent. Do not disclose information on the infant's biological family to the foster family and if the infant returns home, do not disclose information on the foster family to the biological family. The MDHHS child welfare worker is the person responsible for sharing information about the two families. If the infant is still in foster care at the time of discharge, indicate the intervention numbers that were addressed with both the mother and the foster family on the *Discharge Summary* and note in the comments section of the *Discharge Summary* that you have been working with the foster parent and unaware of the mother's status at discharge.

### **Beneficiary Needing Skilled Nursing Care and MIHP Services**

If an infant or mother requires skilled nursing care, such as feeding tube or incision care, it should be provided by a skilled home health nursing agency. A beneficiary concurrently may receive skilled nursing care and MIHP services from the same home health nursing agency, if the agency is a certified MIHP provider.

### **Beneficiary Concurrently Participating in More than One Home Visiting Program**

The Nurse-Family Partnership and MIHP are not to provide home visiting services concurrently to the same beneficiary. However, MIHP beneficiaries may participate in other home visiting programs while they are participating in MIHP.

### **Mother-Infant Dyad Service Options**

Providers may visit only one beneficiary/dyad at a time.

Maternal only MIHP providers are required to serve the mother-infant dyad as follows:

1. Provide all maternal services, including the two required home visits, and after the baby is born, transfer infant to a second certified provider, per written agreement; or jointly provide maternal services with a second certified MIHP provider who would conduct at least one of the two required home visits, and after the baby is born, transfer the infant to the second provider, per a written agreement.
2. Contact the infant services provider with maternal referral information within one month of maternal enrollment in MIHP to prepare for postpartum transition (*for beneficiaries with MRI dated after 7/31/16*).
3. Document in the chart that you followed your specified process for transitioning the beneficiary to the infant services provider-and note if the Infant has been enrolled in infant services, infant services were refused, or it was not possible to locate the infant.

For more information, see *Mother-Infant Dyad Guidelines for Maternal-Only MIHP Providers* on the MIHP website.

## SECTION 5 - REIMBURSEMENT FOR MIHP SERVICES

### Billing Integrated Care Organizations for Services to MI Health Link Beneficiaries

Integrated Care Organizations (ICOs) are responsible for authorizing and paying for Medicaid and Medicare services for MI Health Link beneficiaries. An MIHP provider that serves a MI Health Link beneficiary must discuss a contract, including payment methodology, directly with the beneficiary's ICO.

### Billing for MIHP Services Provided to Individuals Enrolled in Medicaid Health Plans

It is incumbent upon MIHP providers to check Medicaid eligibility and Medicaid Health Plan (MHP) enrollment before providing an MIHP service. MHPs are responsible for authorizing and paying for MIHP services provided to individuals enrolled in MHPs. Billing for these services may include the following:

- In-network MIHP providers: MIHP and MHP negotiated contracts and CCAs will define procedures and rates for reimbursement. These may vary across MHPs.
- Out-of-network MIHP providers: Non-contracted MIHP providers are required to contact the enrollee's MHP before providing out-of-network services and discuss reimbursement details. Any questions related to providing out-of-network services need to be discussed directly with the individual MHP prior to providing services. If services are MHP-approved and provided by an out-of-network MIHP, those services will be reimbursed, at a minimum, at FFS rates.

### Billing MDHHS through CHAMPS for Services Provided to Medicaid

#### Fee-For-Service Beneficiaries

Medicaid beneficiaries who are not enrolled in a Medicaid Health Plan (MHP) have Fee-for-Service (FFS) Medicaid coverage, often referred to as "straight Medicaid." Providers must use appropriate FFS procedure and diagnosis codes when billing for MIHP services. Services provided to FFS beneficiaries are paid by MDHHS according to the MIHP database and fee schedule provided on the MDHHS website. The MIHP provider submits FFS claims to MDHHS electronically through the Community Health Automated Medicaid Processing System (CHAMPS). This requires the agency to have a National Provider Identifier (NPI) and to complete the CHAMPS enrollment process. The provider must have proof that they are an approved Medicaid provider with an MIHP B356 specialty designation before attending a New MIHP Provider Orientation. NPI numbers are in the public domain.

If the beneficiary also has commercial health insurance, a denial from the primary insurance is not required before billing for MIHP services as MIHP services are a Medicaid-only benefit.

An online training titled *Overview of the Maternal Infant Health Program Training Course* is required for all MIHP provider applicants. This training may be accessed at the MIHP website. For additional information on billing and reimbursement, see *Chapter 2 – Medicaid Provider Resources*.

#### Billing Options for MIHP Services to FFS Beneficiaries Prior to Medicaid Health Plan Enrollment Infant Beneficiaries

If the mother is enrolled in a Medicaid Health Plan (MHP) on the date of delivery, the newborn will be enrolled into the same MHP, at least for the newborn's month of birth.

For infant beneficiaries, health plan enrollment is retroactive. This means that once the infant is enrolled in an MHP, the MHP is responsible for paying all MIHP claims dating back to the infant's date of birth.

Billing options for MIHP services provided to infant beneficiaries prior to MHP enrollment are outlined below:

1. The MIHP may bill FFS, but must understand that any FFS payment will be automatically recouped after infant MHP enrollment and the MIHP provider will then need to bill the appropriate MHP. Payments are automatically recouped once every quarter.
2. The MIHP may hold claims submission to the MHP until the newborn's enrollment shows in the CHAMPS eligibility system. The enrollment process normally takes less than 30 days. If it takes longer than 30 days, contact your consultant.
3. If the MIHP knows which plan the mother was enrolled in on the date of delivery, and the newborn has a Medicaid ID number, the MIHP may contact the MHP and ask that a Service Request be submitted to MDHHS to have the enrollment processed. MIHPs should wait until the enrollment shows in the CHAMPS eligibility system before submitting claims.

Regardless of which option the MIHP chooses, the *Infant Risk Identifier* must be entered into the MIHP database upon completion. Infant services must be billed using the infant's Medicaid ID number. If the mother is FFS on the date of delivery, the infant will always be FFS until a MHP enrollment choice is made (normally within 60 days).

#### Maternal Beneficiaries

For maternal beneficiaries, there is no retroactive health plan enrollment. Therefore, the MIHP should bill based on eligibility in the CHAMPS system at the time services are rendered.

#### **Missed Appointments and Phone Calls are Not Billable**

Missed appointments are not billable. If a provider travels to visit a beneficiary as scheduled and finds that the beneficiary is not at home, or if the beneficiary misses an appointment for another MIHP service (e.g., transportation) arranged by the provider, the provider may not bill Medicaid. Also, the provider may not bill the beneficiary for MIHP services. Phone calls to beneficiaries are never billable.

#### **Reimbursement for Different Types of MIHP Services**

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. Some services are billed to the mother's Medicaid ID number and other services are billed to the infant's ID number. After the infant is born, the provider must observe the infant during every visit with the primary caregiver.

The general types of MIHP reimbursable services are as follows:

1. Assessment (using *Maternal or Infant Risk Identifier*) in home or office
2. Professional visit in home or office
3. Professional visit - drug-exposed infant
4. Post-partum lactation support and counseling in home or office
5. Childbirth and parenting education classes
6. Transportation

Reimbursement rates vary by type of service. Special considerations with respect to each of the six service categories are discussed below.

## 1. **Assessment**

The assessment visit is the first visit with the beneficiary. It is conducted in person by either a licensed registered nurse or a licensed social worker.

Assessment involves the administration of the *MIHP Maternal Risk Identifier* or the *MIHP Infant Risk Identifier*. These are mandatory standardized tools that are used to determine a beneficiary's risk level in multiple domains and overall. Results are used to create the beneficiary's *Plan of Care (POC)*. *POC* development is not a separately billable MIHP service.

The *Risk Identifier* assures that all appropriate services are identified prior to the initiation of professional visits, substance-exposed infant visits, lactation support and counseling visits, childbirth education, parenting education or transportation services.

Before an MIHP provider can provide any other MIHP services or bill for the *Risk Identifier*, the provider must administer the *Risk Identifier*, enter the *Risk Identifier* data into the MDHHS MIHP database, obtain a score result, and develop the *Plan of Care, Parts 1-3*. A complete assessment includes the *Risk Identifier* and the complete *POC, Parts 1-3*.

If no scored risks are identified by the *Risk Identifier*, but the provider has written authorization by the consultant to serve the beneficiary based on needs identified by professional judgment, the MIHP provider must document the reason why the beneficiary is being served in the chart.

Even if the provider does not yet have the beneficiary's Medicaid ID number, the provider can enter the *Risk Identifier* into the MIHP database, print it out with the *Score Summary*, develop the *POC*, and provide MIHP services for the beneficiary. However, providers cannot bill for the *Risk Identifier* until the Medicaid ID number is entered into the database. Each agency must decide whether or not they will provide services before a beneficiary's ID number is issued.

Most often, the *Infant Risk Identifier* is administered with the infant's biological mother. However, if the biological mother is not the infant's primary caregiver, the *Risk Identifier* is administered with the individual who is functioning as the primary caregiver.

The *Infant Risk Identifier* visit must be billed under the infant's Medicaid ID number.

You cannot bill for an incomplete *Risk Identifier*.

Even if it takes two visits to fully administer the *Risk Identifier*, only one *Risk Identifier* visit can be billed. Billing cannot occur until the *Risk Identifier* is fully administered. If it takes two visits to complete a *Risk Identifier*, the 2<sup>nd</sup> visit is required within 14 calendar days from the date of the first visit. The date of the second visit is the date that the *Risk Identifier* was administered for documentation and billing purposes; in other words, it is the date of MIHP enrollment.

The *Risk Identifier* data must be entered into the database and placed in the beneficiary's chart with the *Score Summary* before the first professional visit is conducted.

Even if the beneficiary declines MIHP services either before or after the *Risk Identifier* is fully administered, you may bill for the *Risk Identifier* visit.

Reimbursement for the *Maternal Risk Identifier* is limited to one *Maternal Risk Identifier* for each eligible Medicaid beneficiary each pregnancy.

To bill for assessment visits, the provider must use the appropriate Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

## **2. Professional Visits**

Except for transportation, childbirth education classes, and parenting education classes, MIHP services are provided through one-on-one, face-to-face meetings with the pregnant woman or dyad, lasting at least 30 minutes. These meetings are referred to as professional visits. Professional visits are never conducted with groups of beneficiaries. The specific purpose of professional visits is to implement the *Plan of Care*, which is based on the beneficiary's *Risk Identifier* and professional judgment.

### **Maternal Professional Visits**

A pregnant woman is allowed a total of 9 visits in addition to the assessment visit, which is billed using a different code.

A minimum of two home visits are required for maternal beneficiaries. At least one home visit must be conducted within one month of enrollment in the MIHP (for beneficiaries with a MRI conducted after 1/1/17) and one maternal visit must be conducted postpartum (after the infant is born) unless there is a documented reason such as the beneficiary refused services within this timeframe. The *Maternal Risk Identifier* visit may count as one of the two required home visits, although it is not billed as a professional visit. The postpartum visit is billed under the mother's Medicaid ID.

Only one postpartum visit should be completed, even if the beneficiary has not used all of her allotted professional visits by the date of the infant's birth. It is expected that soon after the infant is born, the *Infant Risk Identifier* will be administered, the infant will be enrolled in MIHP, and services will be initiated. This is the case even if the infant's Medicaid ID has not yet been issued, since Medicaid infant eligibility is retroactive to the infant's date of birth and extends throughout the first year of life.

If the maternal beneficiary is hospitalized or incarcerated, MIHP visits must be suspended until she is released.

### **Fetal Loss or Infant Death**

To enroll in MIHP, the Medicaid beneficiary must be pregnant. If the MIHP maternal beneficiary experiences a fetal loss (miscarriage, abortion or stillbirth) or the death of an infant before an infant case is opened or before the infant's Medicaid ID number is issued, the provider may continue to serve the beneficiary until her 9 maternal visits are used or her Medicaid coverage ends, whichever comes first. An MIHP provider may continue to provide MIHP maternal services to a Medicaid eligible woman for up to 60 days after a fetal loss or infant death.

If the infant is enrolled in MIHP and the infant dies after the mother's MIHP coverage has ended, MIHP services are immediately terminated for the mother. Refer the mother to bereavement support services as needed.

### Infant Professional Visits

An infant is allowed a total of 9 professional visits in addition to the assessment visit, which is billed using a different code. Another 9 visits may be provided if an order from the infant's physician is obtained. The order must be written, although a verbal order is acceptable if there is an urgent concern. The reason for and purpose of additional visits must be well documented in the medical record.

Verbal orders should only be utilized if there is an urgent concern that requires the beneficiary to be seen that same day. In all other cases, the medical care provider should send a written order in response to the MIHP authorization request. See *Chapter 3 – MIHP Goal and Primary Partners* for detailed information on verbal orders.

Alternatively, you may use a standing order for the second set of 9 infant visits. A copy of the standing order must be placed in the record. Standing orders must be reviewed and signed by the medical care provider annually. Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 3 – MIHP Goal and Primary Partners*.

### Hospitalized Infant

If an infant is hospitalized after MIHP enrollment, no infant visits can be provided until the infant is discharged from the hospital. This is because the infant must be present at all infant visits and visits cannot take place at a hospital or an incarceration facility.

### All Professional Visits

The *Risk Identifier* must be administered and the *POC 1-3* developed before professional visits (or any other MIHP services) are initiated. If there's a need for an emergency visit after the *POC 2* is developed, but before both of the required *POC 3* signatures have been obtained, then the discipline conducting the visit must have knowledge of the *Risk Identifier* results and the *POC 2*.

Providers may visit only one beneficiary/dyad at a time.

High risk domains must be addressed within the first three visits and this must be documented on the *Professional Visit Progress Note* or the *Contact Log*.

It is expected that visits will be scheduled to accommodate the beneficiary's needs (e.g., work schedule). Beneficiaries, who cannot be seen during the agency's operating hours, must be transferred to another agency that can accommodate their schedules. It is also expected that providers will make appropriate accommodations for Limited English Proficiency, deaf and hard of hearing, and blind and visually impaired MIHP beneficiaries. Required accommodations are detailed in the *MIHP Certification Tool* (Indicator #19) on the MIHP website. Requirements for serving persons with Limited English Proficiency are discussed in *Chapter 6 – Becoming an MIHP Provider*.

Visits should be spaced throughout the period of MIHP eligibility. For example, all 9 maternal visits should not be completed within three months for every woman who enrolls in MIHP early in her pregnancy. Although there are times when this may be required for a particular woman, it should not be done routinely.

If the MIHP provider sends out more than one professional on a home visit, it should last at least 30 minutes, and can only be billed as a single visit. This is true under all circumstances, including when two staff make a joint visit due to concern for staff safety.

Missed appointments are not billable. A visit made solely for the purpose of securing a transfer consent from a beneficiary is not billable. MIHP providers cannot bill for a visit if a beneficiary is enrolled with another MIHP unless the beneficiary has requested a transfer and there is a documented emergency.

MIHP providers are eligible for Medicaid reimbursement for one professional visit (CPT 99402) per beneficiary (or family unit) per calendar day regardless of place of service. If an emergent situation is identified during a professional visit, the MIHP provider should refer the beneficiary to the appropriate resource for further assistance. Two professional visits (CPT 99402) on the same day are not reimbursable.

The date of service on a billing must be the same as the date the professional visit was conducted. The date that the bill is submitted may be different from the date of service.

Medicaid reimbursement for a professional visit includes related case management activities. When beneficiary needs arise, the MIHP provider is required to coordinate all necessary MIHP-related services with the appropriate community agency.

Visits beyond the established limit may not be billed to Medicaid or the beneficiary.

To bill for professional visits, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

### **Conducting *Risk Identifier* and Emergency Professional Visits on the Same Day**

There are very rare occasions when a beneficiary has an emergency need identified during the initial risk assessment visit. At that time, the case manager may assist the beneficiary in seeking additional resources or emergency services. If the RN or SW determines that the services of a second discipline are needed on the same day of service as the risk assessment visit, two separate encounters may be billed. Documentation in the beneficiary's medical record must clearly state the "emergency" need for the second visit. The risk assessment visit and professional visit (by a different discipline) should be made at separately identifiable, documented times. Again, this is only for clearly documented emergency situations.

### **Conducting Postpartum and *Infant Risk Identifier* Visits on the Same Day**

MIHP serves the maternal/infant dyad. When infant services are initiated, an *Infant Risk Identifier* may be billed as a separate visit from a maternal postpartum professional visit when these services are performed on the same date of service. Documentation must substantiate why it was necessary to perform both visits on the same date of service.

Performing postpartum and *Infant Risk Identifier* visits on the same day is only recommended in special, limited circumstances so as not to overwhelm the new mother with information. The *Medicaid Provider Manual, MIHP Chapter, Section 2.9A*, outlines the maternal postpartum visit: *An MIHP provider may complete and bill an infant risk identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the infant risk*

*identifier visit. Providers must document why both visits need to be done on the same date of service. The maternal visit must be a minimum of 30 minutes and be reflected in the professional note.*

The rationale for performing both visits on the same day is at the discretion of the provider. The primary reason that documentation is required is to assure that the needs of the beneficiary are met and that both services are not provided on the same day merely for the convenience of the provider.

Both visits may be conducted by the same individual. All subsequent professional visits for that family should be “blended visits” and billed as “blended visits” under either the parent’s or the infant’s Medicaid ID number.

### **3. Professional Visits – Drug-Exposed Infant**

To use the professional visit - drug-exposed infant billing code (96154), there must be documentation that:

- a. Visits are rendered according to the beneficiary’s *Plan of Care*, based on *Infant Risk Identifier* results and professional judgment.
- b. The infant is, in fact, drug exposed.
- c. The infant’s first 18 professional visits were billed using the preventive counseling code (99402).
- d. A physician order has been obtained authorizing drug-exposed infant visits.

#### **Documentation that Infant is Drug Exposed**

The provider must document that the infant was born with the presence of an illegal drug(s) and/or alcohol in his circulatory system, or that he is living in an environment where alcohol or substance misuse is a danger or suspected. Documentation that the infant was born with substances in his circulatory system can be obtained from the medical care provider. Documentation of suspected substance or alcohol misuse by the mother or others in the home most often consists of professional observations made by the medical care provider or the MIHP provider.

Signs of suspected misuse may include the following: the mother is involved with Child Protective Services related to alcohol or substance misuse; the mother appeared to be high or intoxicated while pregnant; the mother shows signs of being high or intoxicated post-delivery; the mother’s breath smells of alcohol; the home smells of marijuana; someone in the home uses medical marijuana; there are street drugs or drug paraphernalia in the infant’s home; others who live in the home show signs of intoxication, substance misuse, drug dealing; and etcetera.

If the medical care provider or the MIHP provider documents suspected alcohol or substance misuse, the MIHP provider may use the professional visit – drug-exposed infant billing code, after the first 18 visits. Signs observed by the MIHP provider must be documented in *MIHP Professional Visit Progress Note*. MIHP providers may use the drug-exposed infant visit billing code, even if the beneficiary denies using drugs or alcohol.

#### **99402 is Used for First 18 Infant Visits**

MIHP providers may be reimbursed for a maximum of 36 professional visits for a drug-exposed infant. The provider must use the 99402 code to bill the first 18 infant visits, even if the infant is substance exposed at enrollment. After the first 18 visits, the MIHP provider switches to the professional visit drug-exposed infant billing code (96154) for purposes of implementing the *Plan of Care*. It is important to bill

for two (2) units with 96154, as it is a 15 - minute code. If billing does not occur for two units of service, only half of the entitled reimbursement will be received.

### **Using the Substance-Exposed Infant (SEI) Interventions during the First 18 Visits**

The MIHP substance-exposed infant interventions should be used as soon as the professional assesses that the infant is substance exposed and the substance exposed plan of care is implemented. The substance exposed interventions must be addressed on every SEI visit (visits where procedure code 96154 is billed).

### **Physician Order for Additional Infant Visits**

The first 9 infant visits do not require a physician order. If there continues to be a need, the second 9 visits do require a physician order. Additionally, all 18 visits under the drug-exposed infant code require an order. The order must be written, although a verbal order is allowable in an urgent situation when the beneficiary must be seen that day. See *Chapter 3 – MIHP Goal and Primary Partners* for detailed information on verbal orders.

A medical care provider may write a standing order authorizing all additional infant visits (after the first 9 visits), including additional drug-exposed infant visits. A copy of the standing order must be placed in the beneficiary record. The standing order must have been reviewed and signed by the medical care provider within the last 12 months. Additional information on obtaining medical care provider authorization for MIHP services is provided in *Chapter 3 – MIHP Goal and Primary Partners*.

To bill for professional visit - drug-exposed infant, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter.

## **4. Post-Partum Lactation Support and Counseling**

Individual, comprehensive lactation support and counseling services may be provided for post-partum MIHP beneficiaries through 60 days post-delivery. Beneficiaries in the MOMS program are not eligible for these services. Lactation support and counseling services may be provided by a MIHP RN or SW with a valid certification issued by the International Board of Certified Lactation Consultants (IBCLC). Lactation support and counseling services provided by an IBCLC Registered Dietician (RD) are not billable under MIHP, as RDs are not licensed in Michigan. The IBCLC must complete all of the MIHP required trainings and be listed on the *MIHP Personnel Roster*.

The MIHP IBCLC provides evidence-based interventions that, at a minimum, include: instruction in positioning techniques and proper latching to the breast; counseling in nutritive suckling and swallowing; milk production and release; frequency of feedings and recognizing hunger cues; expression of milk and use of pump if indicated; assessment of infant nourishment; and reasons to contact a health care professional. The IBCLC also provides community support referrals, such as to the Women, Infants and Children (WIC) program, as indicated.

Before initiating MIHP IBCLC services:

- The initial MIHP assessment/*Risk Identifier* (infant or maternal) visit must be completed and data entered into the MIHP database.
- The *Plan of Care* (infant or maternal) must be developed and signed.

The *IBCLC Post-Partum Lactation Support and Counseling Professional Visit Progress Note Code S9443* is used to document the provision of MIHP IBCLC services and the evaluation of outcomes from the interventions. The form and instructions are located on the MIHP website.

There must be documentation of the need for maternal lactation support in the beneficiary's chart. MIHP IBCLC services must be provided through a face-to-face encounter lasting at least 30 minutes. There is a limit of two lactation support and counseling visits per beneficiary per pregnancy. These two visits may be conducted in addition to the nine maternal professional visits. Claims are submitted using the mother's Medicaid beneficiary ID with the Healthcare Common Procedure Coding System (HCPCS) code S9443. Documentation must support a separately identifiable visit.

An MIHP agency can bill under both 99402 and S9443 codes for services provided on the same day. When two visits are made on the same date of service, there must be two separate progress notes, a standard *MIHP Professional Visit Progress Note* (99402) and an *MIHP IBCLC Post-Partum Lactation Support and Counseling Professional Visit Progress Note* (S9443). The maternal beneficiary would need to have two postpartum professional visits left in order to bill this way for two lactation visits.

If an MIHP agency does not provide lactation support and counseling services, note that WIC is required to employ a lactation consultant effective October 1, 2017.

## **5. Childbirth and Parenting Education Classes**

Childbirth education (CBE) and parenting education (PE) are provided to groups of people in a classroom setting and cover a variety of topics that are relevant for all beneficiaries regardless of risk level in any particular domain. There are separate billing codes for CBE and PE classes.

### **Childbirth Education Classes**

MIHP providers are required to encourage every first-time mother to complete a childbirth education (CBE) course. The parent must attend at least ½ of the classes or cover at least ½ of the curriculum described in the course outline, before Medicaid is billed.

If your MIHP does not provide CBE classes and refers the beneficiary to an alternative community resource that offers CBE, such as a hospital or another MIHP, the other entity bills for providing the service.

If your MIHP serves an area where there are absolutely no CBE resources, contact your consultant to determine the best way to provide CBE for your beneficiaries.

### **Childbirth Education in the Home**

Under limited circumstances (e.g., beneficiary can't leave home because of a medical condition or she entered MIHP very late in her pregnancy), the provider may choose to conduct in-home CBE as a separately billable service. In this case, the beneficiary record must document the need for one-on-one CBE, where CBE was provided, and that at least ½ of the CBE curriculum was covered. The progress note can be used for documentation purposes.

Alternatively, CBE may be provided in the home and billed as a professional visit. This may be done when there are other extenuating circumstances (e.g., the beneficiary is too anxious or intimidated to participate in a group class).

Case records must document the need for one-on-one childbirth education and where services were provided.

### **Parenting Education Classes**

MIHP parenting education classes can be billed one time per infant or per family in the case of multiple infants. Parenting education classes are not available to parents during pregnancy. They must be billed under the infant's Medicaid identification number. The parent must attend at least ½ of the classes or cover at least ½ of curriculum described in the course outline, before Medicaid is billed. For additional information on CBE and PE classes, see *Chapter 8 – MIHP Service Delivery*.

## **6. Transportation**

Transportation services are available to help MIHP-enrolled pregnant and infant beneficiaries, as well as beneficiaries of the Nurse Family Partnership (NFP), access their health care and pregnancy related appointments, and for a mother to visit her hospitalized infant. Pregnancy-related appointments include those for oral health services, WIC services, behavioral or substance misuse treatment services, and childbirth and parenting education classes.

Transportation needs must be assessed and documented for each MIHP beneficiary. When a transportation need is identified, the beneficiary must be referred to the appropriate transportation resource (e.g., local MDHHS office, Medicaid Health Plan, etc.) The Department of Health and Human Services is responsible for providing medical transportation services to Medicaid-fee-for-service (FFS) beneficiaries, and Medicaid Health Plans (MHP) are responsible for providing medical transportation to MHP enrollees.

Transportation is the only MIHP service available to NFP beneficiaries. Beneficiaries in the NFP do not need a risk identifier completed to receive transportation services.

All transportation services must be provided and documented in accordance with current policy. (Medicaid Provider Manual-Maternal Infant Health Program: Section 2.10 Transportation).

### **Transportation Provided to MHP-Enrollees**

MHPs are responsible for providing transportation for pregnancy-related appointments for MIHP and NFP participants. All services provided by MIHP providers to MHP enrollees should be billed directly to the MHP. MIHPs must follow the MHP's internal processes to coordinate transportation services for MIHP enrollees.

If the mother is enrolled in an MHP at the time of delivery, the newborn's services are also the responsibility of that same health plan, unless the child is placed in foster care. When providing services to a newborn, providers should consult the mother's health plan to be sure that necessary policies and procedures are followed to ensure proper processing of claims submitted.

### **Transportation Provided to Fee-For-Service Beneficiaries**

If transportation needs are assessed for a FFS beneficiary, an MIHP agency may provide transportation to pregnancy-related appointments when no other means of transportation are available. All services provided by MIHP providers to fee-for-service beneficiaries should be billed directly to MDHHS. For an infant whose mother is FFS at the time of delivery, the infant will also be FFS until enrolled in an MHP. All transportation services to FFS beneficiaries must be provided and documented in accordance with current policy. (Medicaid Provider Manual-Maternal Infant Health Program: Section 2.10.B. Transportation for MIHP Fee for Service Beneficiaries.)

## Documenting Transportation Services

MIHP providers must document transportation arrangements in the beneficiary's record. If there is a transportation risk domain in the beneficiary's *POC 2*, it must be documented transportation was provided for the beneficiary and identify the provider on a *Professional Visit Progress Note*.

It is acceptable to provide transportation for a woman who declines professional visits. However, documentation must indicate each of the following: why visits are not being provided; that the woman was offered professional visits on more than one occasion; that the woman was offered a choice of different dates/times for professional visits; and why her MHP is not providing transportation, if applicable.

## Reimbursement for Professional Visits Depends on Place of Service

Reimbursement for professional visits depends on the place of service, reflecting the travel time and costs associated with visiting beneficiaries. When a provider travels to the beneficiary's residence or to a community site requested by the beneficiary, the reimbursement rate is higher than the rate paid if the beneficiary travels to the provider's office or clinic.

MIHP is a home visiting program. At least two of the total maternal visits must be conducted in the home. The *Maternal Risk Identifier* visit may count as one of the two required home visits. At least 80% of all professional infant visits across the total agency caseload, on average, must be provided in the infant's home.

Every effort should be made to provide visits in the home. If a beneficiary absolutely declines home visits (e.g., she lives with her mother who does not want agency workers in her home), MIHP providers don't need to continually ask her if you can make a home visit, but the situation needs to be documented in her chart.

When submitting a claim, the provider must use a Current Procedure Terminology (CPT) Code and a Place of Service Code as documented (see [Billing and Reimbursement](#) in the *Medicaid Provider Manual*).

## Blended Visits

There are times when two or more beneficiaries in the same family have MIHP cases open simultaneously (more than one beneficiary has a *Risk Identifier* but not a *Discharge Summary*). These times include the following:

1. The entire period of infancy for Medicaid-eligible twins, triplets, and other multiples.
2. The period during which an infant is MIHP eligible and the infant's mother is Medicaid eligible due to another pregnancy.

In these situations, *Risk Identifiers* are billed under each family member's own Medicaid ID number. However, when two or more family members have had a *Risk Identifier* completed, professional visits (after the *Risk Identifier* visit) must be blended. This means that two (or more) beneficiaries are served at the same visit, but the visit can only be billed under the Medicaid ID number of one of the beneficiaries.

It's up to the MIHP agency to decide which Medicaid ID to use, based on the situation and needs of the beneficiaries involved. For example, if the mother has unused visits during the postpartum period, the

mother's Medicaid ID can be utilized until all of her visits have been used and then bill under the infant's Medicaid ID. Billing cannot be alternated between the mother and infant's Medicaid ID number.

Blended visits are documented as follows:

1. There is a checkbox at the top of the standard *Professional Visit Progress Note (PVPN)* to document that a visit was blended.
2. *POC 2* interventions provided for the beneficiary whose Medicaid ID is being used to bill are documented in the *Domain/Risk Addressed* sections of the standard PVPN.
3. *POC 2* interventions, referrals and other activities provided for a beneficiary whose Medicaid ID is not used to bill blended visits are all documented under "other visit information" on the PVPN used for the beneficiary whose Medicaid ID is being used to document the blended visit.

The standard PVPN is filed in the chart of the beneficiary whose Medicaid ID is used to bill blended visits or in the family chart.

Each beneficiary has a separate *Consent to Participate*, *Consent to Release Protected Health Information*, *Risk Identifier*, *Plan of Care (Parts 1-3)*, and *Discharge Summary*. Each infant beneficiary also has one or more *ASQ-3 Information Summaries* and one or more *ASQ: SE-2 Information Summaries* in the chart.

The MIHP provider is not required to document the interventions provided for the non-billable beneficiary on the *POC 2*.

## Multiple Births

In the case of multiple births, the following documents are to be completed separately for each infant:

1. *Consent to Participate in Risk Identifier Interview/Participate in MIHP*
2. *Consent to Release Protected Health Information*
3. *Risk Identifier*
4. *Plan of Care*
5. *ASQ-3 and ASQ: SE-2 Information Summary Sheets*
6. *Discharge Summaries*

However, only one *Infant Care Communication* needs to be sent to the medical care provider and MHP, if the infants all have the same medical care provider. In this case, document information about the infants whose Medicaid ID numbers are not being billed in the "Comments" section.

Do not complete the *Infant Forms Checklist* for each infant. The *Infant Forms Checklist* is completed only for the infant whose Medicaid ID is being used to bill blended visits.

*Risk Identifier* and *Discharge Summary* data for each of the infants are entered into the database. The electronic *Infant Risk Identifier* requires entry of the maternal data for each infant.

The *Infant Risk Identifier* is billed under each infant's own Medicaid ID number. However, professional visits (after the *Risk Identifier* visit) must be blended, and all services billed under one infant's Medicaid ID number.

With multiple infant beneficiaries, one infant's Medicaid ID cannot be billed for the initial 9 visits and then another infant's Medicaid ID billed for additional visits. The infant Medicaid ID being billed should

be chosen based on the needs of the beneficiary. In some instances, the healthiest infant is the first one discharged from the hospital. This infant becomes the first one for whom a *Risk Identifier* is done and the one whose Medicaid ID is billed for the blended visits after the other infants come home.

Additional blended visits beyond the initial 9 infant visits for the sibling group may only be provided if a physician's order authorizing additional visits is found in the chart. Developmental screening for infants is critical. A developmental concern identified by the ASQ for one infant is an acceptable rationale for the medical care provider to authorize additional blended visits for the sibling group.

Although *Discharge Summaries* are completed for all of the infants, only the *Discharge Summary* for the infant whose Medicaid ID number is being used for billing purposes is completed in its entirety, and only the interventions provided for the infant being billed are reflected on this *Discharge Summary*. For the other infants, an abbreviated *Discharge Summary* is done. The fields that are not required are grayed out, indicating that data entry is not possible. Do not attempt to enter a *Risk Identifier* and a *Discharge Summary* for a non-billable infant on the same day. Please wait at least 24 hours after entering the *Risk Identifier* before entering the *Discharge Summary*. See *Discharge Summary Forms Instructions* at the MIHP website for details.

Different MIHP agencies may not serve different infants that were born as a multiple pregnancy.

### **Infant is an MIHP Beneficiary and Mother Becomes Pregnant**

If the MIHP agency is visiting an infant and finds out that the mother is pregnant, the infant visit should be completed and the pregnancy documented in the infant's chart. A *Maternal Risk Identifier* can be completed the same day as the infant visit as long as the rationale for doing so is documented (e.g., requested by the mom, a great distance must be traveled). Develop the mother's *POC (Parts 1-3)*, and place it in her chart or add it to the family chart. As is the case for all beneficiaries, the *POC* must be completed before any professional visits can be provided. Bill the *Maternal Risk Identifier* visit under the mother's Medicaid ID.

Visits may continue to be billed under the infant's Medicaid ID or billing may be started under the mother's Medicaid ID. Regardless of billing Medicaid ID chosen, ASQ-3s and ASQ:SE-2s must be completed on the infant.

If billing under the infant's ID and additional maternal risks are identified by the *Maternal Risk Identifier* that weren't included in the infant's *POC 2* as Maternal Considerations, revise the infant's *POC 2* to incorporate the additional risks. Update and sign the infant's *POC 3*, acknowledging the addition of new domains, and send an *Infant Care Communication* to inform the infant's medical care provider of the additional maternal risks, if the mother has consented to release PHI to the infant's medical care provider.

### **Maintaining Charts When Two or More Family Members Have Open MIHP Cases**

Documents for all of the family members being served may be filed in one of three ways:

1. In a family chart
2. In the chart of the beneficiary whose Medicaid ID number is being used for billing purposes.
3. In a separate chart for each family member. If separate charts are maintained, a *Notification of Multiple Charts Open (099)* must be placed in each chart. This form alerts MDHHS consultants and certification reviewers that information about this family is filed in several different charts, reducing the amount of time spent searching for documents during onsite visits. Some agencies find it helpful to have a separate chart for each beneficiary, but to file the charts of all family members in a single hanging folder.

### **Importance of Documentation for Purposes of Medicaid Reimbursement**

Medicaid requires MIHP providers to carefully document the provision of services in the beneficiary's case record. MDHHS provides standardized forms for this purpose. The forms and instructions for completing them are available at the MIHP website at [www.michigan.gov/mihp](http://www.michigan.gov/mihp).

### **Documenting Begin and End Times for MIHP Professional Visits**

MIHP visits must be at least 30 minutes in length in order to be billable. MIHP providers must document begin and end times in the case record for every professional visit. The *MIHP Professional Visit Note* form provides a space to record this information. As a quality assurance activity, it is recommended that the MIHP program coordinator routinely contact a random sample of beneficiaries to verify their visits have been at least 30-minutes long.

### **Date of Service**

The date of service on each claim submitted to CHAMPS must match the actual date of service on the *Risk Identifier* or the *Professional Visit Progress Note*. The date that the progress note was completed and signed may be different from the "Date of Visit" documented on page one of the progress note.

### **Third Party Liability Rules Do Not Apply to MIHP**

MIHP services are a Medicaid-only benefit. MIHP providers are not required to secure other insurance adjudication response(s) for claims for MIHP services prior to billing Medicaid FFS or MHPs, as the parameters of other carriers would never cover MIHP services. In other words, Medicaid's third party liability rules do not apply to MIHP.

## SECTION 6 - BECOMING A MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES MIHP PROVIDER

### Criteria for Becoming an MIHP Provider

Medicaid has specified a comprehensive set of criteria for becoming an MIHP provider. The criteria cover staffing, capacity to provide services geared to the mother-infant dyad, contractual arrangements, facilities, outreach, processing referrals, required services and service protocols, linkages to referral sources, the beneficiary records system, confidentiality, communication with medical care providers and MHPs, and other aspects of provider operations.

### MIHP Provider Application Process

Provider eligibility is discussed in the Medicaid Provider Manual, General Information for Providers, Section 2. This section states: *An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDHHS policy, may enroll as a Medicaid provider.*

Medicaid requires MIHP providers to be certified by MDHHS. A prospective MIHP provider must complete a multi-step application process in order to become certified. The detailed step-by-step *MIHP Application Process*, with timelines, is at the MIHP website.

The process can be lengthy, depending on the applicant's movement through the required steps. Typically, it's between three and nine months after attending the inquiry meeting that an applicant's application is approved.

Technical assistance on how to start up a business is not provided by MDHHS. Providers are responsible for securing and paying for their own legal counsel.

For information on the certification review process, see *Chapter 9 – MIHP Quality Assurance and Improvement*.

### Required Computer Capacity to Use MIHP Electronic Database

MIHP providers are required to enter beneficiary *Risk Identifier* and *Discharge Summary* data into the MDHHS MIHP electronic database. Data collection is intended to improve MDHHS's ability to monitor programs and evaluate program outcomes.

Each provider must have a process for timely, efficient entry of data into the database. Data entry can take place at the provider's office, at the beneficiary's home, or at another location where confidentiality is assured.

Secured internet access is the core requirement to use the database. The State of Michigan determines which Internet browsers must be used. If you use an Internet browser that is not recommended by the State of Michigan, you may have significant, technical difficulties and errors entering and accessing your data.

The acceptable browsers for MIHP MILogin use are Internet Explorer (IE) 8 or IE 11. **You cannot use IE 9 or 10.** The printed version of your *Risk Identifier* and *Discharge Summary* should always be checked for accuracy.

## Required Infant Developmental Screening Tools

MIHP providers must purchase and use the following standardized screening tools and related materials from Brookes Publishing for this purpose:

1. *Ages and Stages Questionnaires, 3<sup>rd</sup> Edition (ASQ-3)*
2. *ASQ-3 User's Guide*
3. *ASQ-3 Learning Activities (book with CD)*  
Available in English and Spanish  
<http://www.brookespublishing.com/store/books/squires-asq/index.htm>
4. *Ages and Stages Questionnaires: Social-Emotional (ASQ: SE-2)*
5. *ASQ: SE-2 User's Guide*  
Available in English and Spanish  
<http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

If the MIHP Agency does not provide infant services, you are not required to purchase the ASQ materials. However, the MIHP agency to which you transition your beneficiaries after the baby is born must purchase and use them. You must ensure that your partnering transition agency is using the ASQ developmental screening tools.

Sharing copies of ASQ materials among MIHP agencies is prohibited under copyright law.

### ASQ-3 Materials Kit

The *ASQ-3 Materials Kit* may be purchased, which includes approximately 20 toys, books and other items designed to encourage a child's participation and support effective, accurate administration of the questionnaires. The *Materials Kit* is available from Brookes Publishing: <http://agesandstages.com/>

Materials that are available in the parent's home may also be used to administer the ASQ-3. The advantage to using materials in the home is that you can show parents how everyday items can be used to promote child development. Please assure that household items are evaluated for safety and pass "the choke test."

## Provider Authorization of MIHP Electronic Database Users

The MIHP provider must authorize staff members to use the State of Michigan MILogin System in order to enter MIHP data into the MDHHS electronic database. Unauthorized staff will be denied access. Only individuals working for the MIHP provider can be authorized.

Any staff authorized by the MIHP program coordinator to use the MILogin System may enter *Risk Identifier* and *Discharge Summary* data into the MDHHS database, including support staff.

The MILogin System authorization process is as follows:

1. The MIHP program coordinator emails a complete and updated *MIHP Personnel Roster* with the first and last name(s) of all staff members. The license numbers and license expiration dates for professional staff, work experience, etc., must be entered. All of the fields on the *Personnel Roster* **must** be completed. An **X** is placed under the **MILogin/MIHP column** to indicate the staff member(s) that will be using the MIHP electronic database. The MIHP program coordinator lists the new usernames in the body of the email.
2. An updated *Personnel Roster* is required to be emailed to [mihp@michigan.gov](mailto:mihp@michigan.gov) within 30 days after the end of every quarter (quarters end on December 31, March 31, June 30 and September 30). Due dates are: January 30, April 30, July 30 and October 30. To maintain access, all staff members authorized to use MILogin must be listed on the current *MIHP Personnel Roster*.
3. To authorize a new staff member to use MILogin prior to the end of the quarter, submit a complete and updated *MIHP Personnel Roster*. MIHP Agencies are required to submit an updated *Personnel Roster* within 10 days of any agency personnel change.
4. The MIHP provider receives an email message confirming the names of the authorized users.

Questions regarding this process should be directed to your consultant.

## Registration of Individual Authorized Users through Michigan's MILogin System

Authorized individual(s) must register through Michigan's MILogin System. Only individuals who are registered with MILogin can access the database. The registration process is outlined below:

1. Individual (s) goes to the state's MILogin System website at <https://milogintp.michigan.gov>
2. The individual follows the instructions on the MILogin System website to obtain a User ID and Password.
3. The individual writes down and safeguards the User ID and Password.

Every authorized user must create their own MILogin user name and password. MIHP program coordinators cannot create usernames for staff members.

Because MIHP data is protected health information, each staff who will have access to MILogin must sign a confidentiality agreement before being authorized as a user. It is acceptable to use the *MIHP Field Confidentiality Guidelines (4-27-17)* as the confidentiality agreement if you add the following statement: *I have read and will follow these guidelines* and provide spaces for staff signature and signature date. The statement must be kept on file and each staff must have their own copy.

An individual who works for more than one MIHP agency must have a separate MILogin authorization and password for each agency, given that access is based on the agency's NPI number.

## Entering Data into the MIHP Database to Complete Electronic Forms

At this time, data must be entered into the MIHP database in order to complete four electronic forms: *Maternal Risk Identifier*, *Infant Risk Identifier*, *Maternal Discharge Summary*, and *Infant Discharge Summary*. Do not attempt to enter a *Risk Identifier* and a *Discharge Summary* for the same beneficiary on the same day. A *Discharge Summary* cannot be entered until 24 hours after entering the *Risk Identifier*.

When data entry errors have been discovered on forms submitted to MDHHS, the form may need to be deleted and re-entered. An internal data entry quality improvement process is recommended.

### **Entering Electronic *Risk Identifiers* and *Discharge Summaries* into the Chart after Data is Completely Entered into the MIHP Database**

After the *Risk Identifier* is administered and the data has been entered into the MIHP database, required file both the *Risk Identifier* and *Score Summary* in the beneficiary's chart. This must be done before the first professional visit is conducted or any other MIHP services are provided. This is required whether or not the beneficiary has obtained a Medicaid ID number at the time of enrollment. All staff must have immediate access to the *Risk Identifier* and *Score Summary* in order to best serve the beneficiary.

It is required to enter the *Discharge Summary* in the beneficiary's chart before sending the *Notice of MIHP Beneficiary Discharge* to the medical care provider and the MHP. This notice must be sent within 14 days from the date the *Discharge Summary* is entered into the database. Send the *Discharge Summary* with the notice to the medical care provider, but not to the MHP.

The *Risk Identifier* and *Score Summary* must be entered in the chart before the first professional visit is conducted and the *Discharge Summary* must be entered in chart the before the *Notice of MIHP Beneficiary Discharge* is sent to the medical care provider and the MHP. All of these documents (if applicable) must be in the chart when the chart is pulled at the time of certification review.

### **Agencies Using Electronic Medical Records**

MDHHS is supportive of MIHP agencies that convert to Electronic Medical Record (EMR) systems. An agency may incorporate MIHP forms within an EMR system as follows:

1. Request access to a set of unprotected/unlocked MIHP required forms to upload into EMR system. All of the MIHP required and optional forms are included in the set of unprotected/unlocked forms. The form to request access to MIHP forms in an unlocked format may be found on the MIHP website under "Policy and Operations" titled *Request for Unprotected Forms*. The request form must be completed by an authorized agency representative.

By signing the request form, the agency agrees not to change the MDHHS forms in any way unless MDHHS has approved the change. The agency also agrees to accept responsibility for modifying the forms whenever revised by MDHHS. Upon receipt of the request, MDHHS will render a decision regarding approval.

2. Any software package to duplicate the forms, but the forms must contain all required data fields in the order given on the current MIHP forms.
3. Electronic letterhead on MIHP documents may be used, but you must maintain the document titles.
4. Password protected electronic signatures may be used. This applies to all MIHP forms requiring signatures, including the Professional Visit Progress Note (PVPN). There must be verification of a secured log-in for typed signatures.

5. After scanning signed forms (e.g., Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP, Consent to Release Protected Health Information, Professional Visit Progress Note) into the individual EMR, shred the original. Paper copies of signed consent forms are not needed when utilizing an EMR system.
6. If a staff faxes in chart documentation (e.g., Professional Visit Progress Note) while in the field, the original must be in the chart within 14 days of the date of the visit.
7. All EMRs should be backed-up.
8. It is required to maintain the Infant Forms Checklist and the Maternal Forms Checklist when using an EMR system. The Forms Checklists can be completed electronically, if the EMR report contains all of the data elements and the MDHHS reviewer can follow it. It is acceptable to run a report which gives the dates of the encounters for the beneficiary and staple it to the back of the Forms Checklist form.
9. Two options are available when asked to provide beneficiary charts for an onsite certification review. You can print out paper copies of the requested charts or assign a staff person to assist the reviewer to read the charts on a computer monitor. This staff would need to be available throughout the two-day review, as needed.
10. Charts must be available upon request by any agent of the state.
11. Scan and save the entire electronic Risk Identifier, Risk Identifier Score Summary, and the entire Discharge Summary in the EMR system.
12. If agency's data is needed from the MDHHS database for the EMR system, contact assigned MIHP consultant to inquire about the file transfer process and Data Use Agreement. The MIHP Provider Data Transfer File Request Form must be completed in order to request permission to electronically upload the MIHP data. The file transfer process will work with any EMR platform. The individual agency's IT staff will have to adjust their programming to accept data from MDHHS.
13. When doing quality assurance, make sure that all of the MIHP forms have been scanned into the record, including consent forms.
14. The MDHHS Public Health Legal Adviser responded to four questions about the use of electronic signatures in MIHP on March 17, 2011, as follows:

**Question 1:** Is a "typed" signature on a MIHP form that is imported into an electronic medical record constitute a valid signature?

Short answer: Yes, an electronic signature has the same legal significance as a written signature as long as it is intended to be a signature, and the creation of the signature can be attributed to the person. Note that the efficacy of the security procedures in place will pertain to a determination of whether a signature is attributed to a person.

Citations: Under the Uniform Electronic Transactions Act, (MCL 450.831 *et seq*), an electronic signature can be any symbol or process associated with a record as long as it is used with the intent to sign the record, so a typed signature can be used. (MCL 450.832(h)). A record or signature shall not be denied legal effect or enforceability solely because it is in electronic form. (MCL 450.837(1)). An electronic signature satisfies the legal requirement for a signature. (MCL 450.837(4)). Also, the context and surrounding circumstances of the creation of the signature and record determine how these acts will be attributed to a person, and include demonstration of the efficacy of the security procedures applied in the creation or execution of the signature or record. (MCL 450.839).

**Question 2:** Are scanned and imported documents are considered "authentic"?

Short Answer: Yes, a scanned record has the same legal effect as a written record. Further, if there is a legal requirement for retention of a record, the requirement is satisfied by retaining an electronic record as long as the record accurately reflects the information in the final form, and remains accessible for further use.

Citation: "Electronic record" means a record created, generated, sent, communicated, received, or stored by electronic means. (MCL 450.832(g)). An electronic record has the same legal effect and enforceability as a written record. (MCL 450.837(1) and (3)). If a law requires that a record be retained, the requirement is satisfied by retaining an electronic record of the information as long as the electronic record accurately reflects the information set forth in the record after it was first generated in its final form as an electronic record or otherwise, and remains accessible for later reference. (MCL 450.842(1)). A record retained in this manner also satisfies a legal requirement to retain a record in its original form, as well as for evidentiary, audit, or similar purposes unless the subsequent law specifically prohibits the use of an electronic record for a specified use. (MCL 450.832(4) and (6)).

**Question 3:** Are there are any restrictions for the use of signature pads in MIHP?

Short answer: Electronic signature software and pads are designed for the capture, binding, authentication, and verification of electronic signatures in digital documents. As long as the intent and attributability requirements set forth above are satisfied, then the legal requirements for a signature would be satisfied.

**Note:** These provisions apply to any electronic record or electronic signature created, generated, sent, communicated, received, or stored on or after October 16, 2000.

## Official Agency Telephone

The telephone number listed in the *MIHP Coordinators Directory* is the agency's official telephone number. It may be a land line or cell phone number.

The official telephone number should be used for agency business only. Calls coming into this number should be answered professionally with a statement that includes the name of the MIHP. This phone must not be accessible to family members or others who are not authorized to handle Protected Health Information (PHI).

The agency phone number must have a voice mail message that includes:

1. The name of the MIHP
2. Directions on what the caller should do if she is in an emergency situation during the work day, after hours, or on the weekend. Directions should include calling 9-1-1 or going to the emergency room.
3. Directions for leaving a call-back number with a statement indicating when the caller may expect a return call.

Voice mail messages must be checked and deleted frequently. The caller should never be denied the opportunity to leave a message because the voice mail box is full.

MIHP state-level staff or MHP staff may call the agency number periodically to determine, if the phone is being answered professionally and in keeping with the requirements listed above.

## **Confidentiality Requirements for Transmission and Maintenance of MIHP Beneficiary Information**

MIHP providers carefully must follow the *MIHP Field Confidentiality Guidelines* developed by MDHHS. The guidelines are available at the MIHP website. Please take special note of the following points:

1. Beneficiary information must be encrypted before it can be sent electronically. Using the beneficiary's name, even though no other identifying information is provided, is not acceptable in electronic communications sent to medical care providers or MHPs. MIHP providers that wish to send communications electronically must use encryption software.

Refrain from sharing beneficiary protected health information when using various methods of online and electronic communication (e.g., fax, e-mail, and text) unless they have been verified as secure to ensure you are not violating Health Insurance Portability and Accountability Act (HIPAA) or confidentiality guidelines. To learn more about Health Information Privacy, visit <http://www.hhs.gov/hipaa/for-professionals/index.html>

You are not required to encrypt information on your smart phone if the beneficiary indicates that calling or texting her is the best way to reach her. The beneficiary is asked this question during the administration of the *Risk Identifier*.

2. All staff with access to protected health information must sign confidentiality statements. This includes the coordinator, the owner, professional staff, administrative staff, data entry staff and anyone else who has access to PHI. The agency must keep these statements on file.
3. A double-locking system is required in all agencies for beneficiary records. This means that records must be stored two locks away from anyone who is not authorized to see the beneficiary's PHI in order to prevent inadvertent exposure.
4. A double-locking system is also required when staff take beneficiary records into their homes. This means that records must be stored two locks away from anyone who is not authorized to see the beneficiary's PHI in order to prevent inadvertent exposure. If no one else has access to the home, records can be stored in a locked office in the locked house. If other people,

including family and friends, have access to the house, records can be stored in a locked cabinet in a locked office or in a locked briefcase in a locked cabinet. A double-locking system must also be used when transporting records.

5. If an agency violates the Health Insurance Portability and Accountability Act (HIPAA), the agency, not MDHHS, is responsible for securing legal counsel should it become necessary. MDHHS attorneys do not represent MIHP agencies that breach confidentiality or in other legal matters.

All staff must have a copy of the *MIHP Field Confidentiality Guidelines*. Agency contracts must include language requiring contractors to meet HIPAA standards, including record retention requirements for contractors who store the agency's paper or electronic records.

## Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is the Health Insurance Portability and Accountability Act of 1996, a law intended to make it easier for people to keep their health insurance when they change jobs. The law set standards for the electronic exchange of patient information, including protecting the privacy of such records. The U.S. Department of Health and Human Services issued the Privacy Rule to implement that aspect of the law, and its Office of Civil Rights is in charge of enforcing it. HIPAA was enacted to cover three specific areas:

1. Insurance portability or the ability to move to another employer and be certain that insurance coverage will not be denied
2. Fraud enforcement and accountability
3. Administrative simplification

Insurance portability and fraud enforcement and accountability have been active since 1996; however, it took until April 2003 to enact administrative simplification. In January 2013, further amendments were made to HIPAA law, to further protect patient privacy, secure health information and enhance standards to improve privacy protections and security safeguards for consumer health data. The final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law. Administrative simplification refers to the guidelines that impact healthcare providers in the communications with other providers, families, friends and the media. The overall intent of this act is to make it easier for the consumer to obtain seamless care, irrespective of the number of different providers they see; while still protecting the confidentiality and privacy of the patient.

**Covered entities** are health plans (including health insurance companies and employer sponsored health plans), health care clearinghouses, and health care providers that engage in defined electronic standard transactions, which generally relate to insurance reimbursement. Examples include hospitals, ambulances/emergency medical technicians, private physicians and social workers. MIHP providers are considered covered entities.

**Protected Health Information** is *individually identifiable* health information created, received, transmitted and/or maintained by a covered entity. This includes information relating directly or indirectly to the person's past, present or future physical or mental health, the provision of care to the person, and the person's health care bills and payments. This information includes the following demographics:

1. Name
2. Address (all geographic subdivisions smaller than state, including street address, city, county, or Zip code.
3. All elements (except years) of dates related to an individual (including birth date, admission date, discharge date, date of death, and exact age if over 89)
4. Telephone numbers
5. FAX number
6. Email address
7. Social Security number
8. Medical record number
9. Health plan beneficiary number
10. Account number
11. Certificate/license number
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers or serial numbers
14. Web URLs
15. Internet Protocol (IP) address
16. Biometric identifiers, including finger or voice prints
17. Full-face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

### Privacy and Security

Any method used to transmit protected health information must be secure, including verbal transmission. Be sure not to discuss a beneficiary with another individual in a public setting of any kind, on the phone or face-to-face. Do not talk to any unauthorized person (family, friends, etc.) about a beneficiary at any time or any place, even if you do not state the beneficiary's name. Do not indicate any part of the beneficiary's residence.

All staff must maintain security during:

- Record delivery, ensuring that transported PHI is delivered only to individuals who are authorized to receive the information.
- Service delivery, carrying only the minimum identifiable information necessary to provide service in the field.

Agencies are required to become familiar with HIPAA and understand how the law affects MIHP program operations. See <http://www.hhs.gov/ocr/privacy/index.html> for additional information. Also see Indicators #13, #14 and #16 in the *MIHP Certification Tool* for MIHP confidentiality requirements.

### Requirements for Serving Persons with Limited English Proficiency

On Aug. 11, 2000, President William J. Clinton signed Executive Order 13166: *Improving Access to Service for Persons with Limited English Proficiency*, to clarify Title VI of the Civil Rights Act of 1964. The executive order was issued to ensure accessibility to programs and services by otherwise eligible individuals not proficient in the English language. The executive order stated that individuals with a limited ability to read, write, speak and understand English are entitled to language assistance under Title VI of the Civil Rights Act of 1964 with respect to a particular type of service, benefit, or encounter.

These individuals are referred to as being limited English proficient in their ability to speak, read, write, or understand English, hence the designation, “LEP,” or Limited English Proficient.

The executive order states that: *Each federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency’s programs and activities.*

Not only do all federal agencies have to develop LEP plans as a condition of receiving federal financial assistance, recipients have to comply with Title VI and LEP guidelines of the federal agency from which funds are provided as well. Recipients of federal funds, including MIHP, range from state and local agencies to nonprofits and organizations. Title VI covers the recipient’s entire program or activity. *This means all parts of a recipient’s operations are covered, even if only one part of the recipient’s organization receives the federal assistance.*

Between 1990 and 2013, the LEP population grew 80 percent from nearly 14 million to 25.1 million. The growth of the LEP population during this period came largely from increases in the immigrant LEP population. The most dramatic increase occurred during the 1990s as the LEP population increased 52 percent. The growth rate then slowed in the 2000s and the size of the LEP population has since stabilized. Over the past two decades, the LEP share of the total U.S. population has increased from about 6 percent in 1990 to 8.5 percent in 2013.

Spanish has been the predominant language spoken by both immigrant and U.S. - born LEP individuals. About 64 percent (16.2 million) of the total LEP population speaks Spanish, followed by Chinese (1.6 million, or 6 percent), Vietnamese (847,000, 3 percent), Korean (599,000, 2 percent), and Tagalog (509,000, 2 percent). Close to 80 percent of the LEP population spoke one of these five languages.

In Michigan, Spanish and Arabic languages meet the threshold for inclusion in LEP mandates. Of the approximately 81,000 LEP individuals in Michigan, 42.9 % speak Spanish and 26.3 % speak Arabic, followed by Bengali (2.8%), Albanian (2.2%) and Vietnamese (1.8%).

MIHP agencies have options in serving persons with LEP. For example, they may hire an interpreter (verbal communications) and/or translator (written communications) or purchase these services from a commercial entity such as LanguageLine. All interpreting and translation services used by MIHP must meet LEP guidelines. For additional information, go to the Office of Civil Rights link at the MIHP website under “Policy and Operations.”

## **Guidelines for an Office in the Provider’s Place of Residence or Other Location where Beneficiaries are Not Seen**

MDHHS has developed guidelines for providers using their place of residence as an MIHP office or who have offices in other locations where beneficiaries are not seen. Providers with these types of offices are required to follow the guidelines. The guidelines are available at the MIHP website.

A provider whose home address is listed as their office address in the *MIHP Coordinators Directory* may choose to list as a P.O. Box. To make this change, send an email to [MIHP@michigan.gov](mailto:MIHP@michigan.gov), indicating the P.O. Box as the contact address for your business. Note that MDHHS must have your current home address on file for MIHP use.

## **Emergency Services**

MIHP agencies must provide for beneficiary emergencies that occur during the workday, after hours or over the weekend. Beneficiaries need to be informed about accessing services outside of the agency's operating hours. The agency must ensure that there is an after-hours message with emergency information on the main MIHP agency phone system, including directions to call 9-1-1 or go to the ER.

The phone number given to beneficiaries to access MIHP services must have the after-hours message. If an agency gives out two phone numbers, both must have the after-hours message. If the agency phone is a cell phone, it must have the have the after-hours message.

## SECTION 7 - MIHP MARKETING AND OUTREACH

### Marketing the MIHP in the Community

Marketing the MIHP is an ongoing activity for MIHP providers. Marketing is the process of promoting awareness of MIHP in order to identify and engage community partners as referral sources.

Typical community marketing strategies include the following:

1. Conducting MIHP presentations at community agencies, places of worship, and other locations where community members come into contact with pregnant, low-income women or infants.
2. Placing and maintaining posters and brochures or fliers in locations frequented by pregnant, low-income women (e.g., WIC agencies, local health departments, grocery stores, dollar stores, etc.).
3. Developing good relationships with entities that are in a position to refer a significant number of women to the MIHP (e.g., WIC agencies, MHPs, medical care providers, etc.).
4. Providing potential referral sources with an easy referral process.
5. Participating in local coalitions that work to improve maternal and child health or to coordinate services for identified children and families, such as:
  - a. Infant mortality reduction coalitions
  - b. Great Start Collaboratives (local groups building early childhood comprehensive systems focusing on Pediatric and Family Health, Social-Emotional Health, Parenting Leadership, Family Support, and Child Care and Early Education)
  - c. Fetal-Infant Mortality (FIMR) Teams
  - d. *Early On* Local Interagency Coordinating Councils
6. Maintaining a website and/or social media tools

A standardized *MIHP Provider Information Sheet* has been developed for MIHP providers to distribute statewide to medical care and social service providers. The *MIHP Provider Information Sheet* can be downloaded and printed from the MIHP website. Although it was designed in color, it also prints out well in black and white.

MIHP providers, need to repeatedly market their services to potential referral sources due to staff turnover. This will ensure health and human services workers have access to current information about the availability of MIHP services in their community.

Different providers market their services in different ways. For example, some conduct marketing activities on an ongoing basis; others do a week-long blitz once a year. Only providers that have a single, regular referral source (e.g., prenatal clinic) are exempt from conducting outreach activities.

It's important to thoughtfully cultivate relationships with prospective referral sources. There are many ways to do this, but all successful referral relationships are built on a foundation of respect and professionalism. Your knowledge of your program, demeanor, communication style, appearance and behavior reflect not only on your particular MIHP, but on MIHP statewide.

### Marketing the MIHP to MHPs

MDHHS requires MHPs to refer their pregnant and infant enrollees to an MIHP. MHPs will determine which MIHP providers they will contract with based on several factors including service area, quality, responsiveness, specialty and network adequacy.

It is the MIHP provider's responsibility to ensure that every MHP operating in their service area is familiar with the MIHP agency. The provider should develop good working relationships with each MHP so that the MHP will feel confident in referring its members to the provider's program.

### **Marketing the MIHP to Medical Care Providers**

MIHP services are intended to supplement prenatal and infant medical care in order to promote the beneficiary's health and well-being. A medical care provider may be a physician, certified nurse-midwife, pediatric nurse practitioner, family nurse practitioner or physician assistant. As a group, medical care providers have not been a primary source of referrals to MIHP, likely because many of them are not familiar with the program. MHPs do educate their in-network medical care providers about MIHP and encourage them to make MIHP referrals, but MHPs do not contractually require their providers to refer to MIHP.

It's important for MIHP providers to market themselves to medical care providers, especially obstetricians and pediatricians, so that the medical care providers will make MIHP referrals and understand how the MIHP provider will coordinate with them when they are serving the same beneficiary. (Medicaid policy requires the MIHP provider to coordinate with the beneficiary's medical care provider at specified points throughout the MIHP service process, from intake to case closure, using standardized forms.)

MIHP providers are especially encouraged to market their services to medical care providers serving large numbers of low-income pregnant women and infants, such as Federally Qualified Health Centers, community health centers, etc. It is suggested that providers also market their services to staff at local birthing hospitals, as they are in a position to refer women and infants to MIHP at the time of discharge.

MDHHS does not provide a standardized form for medical care providers to use to refer their patients to MIHP. MIHP providers may wish to develop their own form for this purpose.

### **MIHP Outreach to Potential Beneficiaries**

Outreach is another ongoing activity for MIHP providers. Outreach has two main components:

1. Broadly advertising the program to potential beneficiaries.
2. Identifying a particular pregnant woman, mother of an infant, or other primary caretaker of an infant, who may be eligible for MIHP and reaching out to her to explain the program and encourage her to participate.

### **Broadly Advertising MIHP**

MIHP providers have used one or more of the following methods to broadly advertise MIHP to potential beneficiaries:

1. Maintaining a professional website.
2. Maintaining a professional agency Facebook page.
3. Talking about the program on a local TV or radio show.
4. Participating in community baby showers or health fairs.
5. **With permission from the individual or entity**, leaving brochures or posters at physician's offices, laundromats, grocery stores, dollar stores, food banks, places of worship and other locations throughout the community.

A standardized *MIHP Parent Information Sheet* has been developed for MIHP providers to distribute to potential MIHP beneficiaries statewide. It is available in English, Arabic and Spanish. The *MIHP Parent Information Sheet* is written at the 6th grade reading level. It can be downloaded and printed from the MIHP website. Although it was designed in color, it also prints out well in black and white. Some providers develop their own brochures to distribute to potential MIHP beneficiaries.

If you are working with a population that does not speak English, Arabic or Spanish, and wish to translate the brochure into another language, you must contact MDHHS to request permission to do so.

### **Directly Contacting Potential MIHP Beneficiaries**

Most MIHP providers spend a great deal of time and effort identifying and personally contacting potential beneficiaries in order to market MIHP. They use several different methods to do this.

One method is face-to-face outreach at a community agency. This requires permission from the agency, allowing the provider to visit the agency to approach potential beneficiaries (e.g., in the waiting room), and then take them to a private space to talk. Do not attempt to solicit beneficiaries without the permission of the outreach location.

Direct contact is also done by phone, mail, or cold-call home visits. These methods are used when a referral source supplies the MIHP provider with the names of potential MIHP beneficiaries, along with their phone numbers and/or addresses.

### **Outreach through Partnerships**

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and MHPs generate a great number of MIHP referrals. MIHP providers should promote sound partnerships with WIC and MHPs, but in areas of the state where there are numerous MIHP providers, especially Southeast Michigan, you may need to develop alternative outreach partners.

Five common potential outreach partners are described below.

#### **Outreach through Partnerships with Women, Infants, and Children (WIC)**

WIC is an absolutely critical partner in identifying potential MIHP beneficiaries. Most WIC programs are operated by local health departments (LHDs), but some are operated by other community agencies. There are two different ways in which WIC can partner with an MIHP provider to identify potential MIHP beneficiaries:

1. A WIC agency may agree to allow an MIHP provider to conduct outreach activities on its premises during clinic hours.
2. A WIC agency may agree to fax or send written referrals to an MIHP provider.

It is easiest for WIC to partner with the MIHP provider when an LHD operates both the WIC and MIHP programs. However, private MIHP providers may also work out partnering agreements with LHDs that don't operate their own MIHPs or with LHDs that do operate their own MIHPs, but don't have the capacity to provide MIHP services for all of the women who come through their doors. Private providers may also work out partnering agreements with WIC agencies other than LHDs.

#### **Outreach through Partnerships with LHDs Involving Programs Other than WIC**

It may be possible for an MIHP provider to partner with the LHD to conduct outreach activities through LHD maternal-child health programs besides WIC. LHDs don't all offer the same maternal-child health

programs, but may offer Medicaid outreach and enrollment, prenatal clinics, immunization clinics, and home visiting programs other than MIHP.

### **Outreach through Partnerships with MHPs**

MHPs are required to refer their eligible pregnant and infant enrollees to MIHPs. Some MHPs rotate referrals among all of the MIHP providers in a given county and others refer only to MIHP providers with whom they have established good working relationships. MHPs may refer to the MIHPs of their choice, but they cannot dictate that a beneficiary must enroll in a particular MIHP. The beneficiary may choose from among all of the MIHPs contracted with the MHP.

The *MIHP-MHP Communication Tool* has been developed for use by both MHPs and MIHPs to share information about mutually-enrolled beneficiaries on a monthly basis. The form can be generated by the MHP or the MIHP. This form replaces the *MIHP-MHP Referral Status Report Form*. The form and instructions for its use are available at the MIHP website. In order to maintain consistency for everyone, MHPs and MIHP providers must use this form without making alterations.

MIHPs are encouraged to communicate with the MHPs about any specialty services they are able to provide (e.g., culturally or linguistically appropriate services). MIHPs should assure the *MIHP Coordinators Directory* accurately reflects their specialty services.

### **Outreach through Partnerships with Federally Qualified Health Centers (FQHCs) and Large-Volume Prenatal Clinics**

FQHCs and large-volume prenatal clinics that do not operate their own MIHPs may also serve as MIHP referral sources.

### **Outreach through Partnerships with Birthing Hospitals**

Some MIHP providers get most or all of their infant referrals through partnerships with birthing hospitals. MDHHS works with birthing hospitals across the state to see that all Medicaid-eligible infants are referred to MIHP or Children's Special Health Care Services before discharge. MIHP providers should reach out to all birthing hospitals in the agency area.

### **Respecting Outreach Relationships Developed by Other MIHP Providers**

Many MIHPs have developed outreach relationships with particular community organizations. Some of these relationships are long-standing. If approaching an organization that already has a relationship with another MIHP and is allowing that MIHP to conduct outreach activities on its premises, respectfully move on to another organization.

MIHPs are asked to recognize the importance of continuity of care while performing outreach activities. It is expected that new providers who are leaving the employment of another MIHP to open their own MIHP will not encourage beneficiaries to transfer to their new agency. If a woman was served by an MIHP during her pregnancy, it is recommended that she continue with that MIHP after her infant is born. However, it is ultimately up to the beneficiary to decide whether or not to transfer to a new MIHP provider. If the beneficiary is in an MHP and decides to transfer, she must choose an in-network MIHP provider.

## Locating MIHP Marketing and Outreach Partners

MIHP providers need to be familiar with the particular entities in their respective service areas that frequently come into contact with low-income pregnant women and infants, as these entities are potential marketing and outreach partners.

Local United Way offices are a good source of information about community resources, including resources for low-income pregnant women and infants. To find the United Way in your area, go to [www.unitedway.org/find-your-united-way](http://www.unitedway.org/find-your-united-way).

The Michigan Association of United Ways website includes information about 2-1-1, a health and human services telephone referral system that's available 24 hours a day, 7 days a week, 365 days a year in 180 different languages, covering 99% of Michigan's population.

Local agencies, such as the Local Health Department, local Department of Health and Human Services, or Community Action Agency, may have developed resource and referral guides and posted them online. An Internet search for "\_\_\_\_\_ County Community Resources" is likely to generate multiple resource guides.

Although every community is different, the following is a list of MIHP potential marketing and outreach partners common to most:

1. Supplemental Nutrition Program for Women, Infants and Children (WIC)

MDHHS WIC Program

[http://www.michigan.gov/mdhhs/0,5885,7-339-71547\\_4910\\_6329---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4910_6329---,00.html)

MDHHS WIC Agency List (by County)

[http://www.michigan.gov/documents/mdch/WIC\\_Agency\\_List\\_382084\\_7.pdf](http://www.michigan.gov/documents/mdch/WIC_Agency_List_382084_7.pdf)

To find local WIC agency: 1-800-26-BIRTH

2. Medicaid Health Plans

A list of MHPs by county is available at:

[www.michigan.gov/MDHHS/0,1607,7-132-2943\\_4860\\_5047---,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2943_4860_5047---,00.html)

The *MHP Single Point of Contact List for MIHP* provides contact information for the Contracts/Provider Services Representative and the Care Coordination Liaison for each MHP.

3. Medical Care Providers

Ask the Local Health Department or refer to the phone book or Internet to identify medical care providers. Develop relationships with key staff at obstetric offices, prenatal clinics (especially high-volume clinics serving Medicaid beneficiaries), newborn nurseries, pediatric clinics and offices, Federally Qualified Health Centers, hospitals (especially discharge planners), and childbirth education programs. Make sure that social workers affiliated with prenatal clinics and hospitals know how to refer to your program. To identify Federally Qualified Health Centers in your locale, go to:

[www.wheretofindcare.com/FederallyQualifiedHealthCenters/Michigan-MI/City.aspx](http://www.wheretofindcare.com/FederallyQualifiedHealthCenters/Michigan-MI/City.aspx)

4. Free and Low Cost Health Care in Michigan  
[www.michigan.gov/mihp](http://www.michigan.gov/mihp)  
[Migrant Health Centers in Michigan](#)
5. Local Health Departments (LHDs)  
Many LHDs are MIHP providers.  
Local Public Health Department Locator  
<http://www.malph.org/>
6. Department of Health and Human Services Local Offices  
<http://www.michigan.gov/dhs/0,1607,7-124-5461---,00.html>
7. *Early On* Michigan  
<http://www.1800earlyon.org/>
8. Great Start Collaboratives – Early Childhood Investment Corporation  
<http://www.greatstartforkids.org/content/great-start-your-community>
9. Michigan Domestic Violence Resource Directory  
[http://www.michigan.gov/som/0,1607,7-192-29941\\_30586\\_240---,00.html](http://www.michigan.gov/som/0,1607,7-192-29941_30586_240---,00.html)
10. Community Mental Health Services Programs  
Michigan Association of Community Mental Health Boards Members  
<http://www.macmhb.org/BoardList.html>
11. Office of Recovery Oriented Systems of Care (ROSC)  
Oversees prevention, treatment and recovery efforts related to substance misuse and mental health disorders and problem gambling addictions in Michigan; provides links to community-based services [http://www.michigan.gov/MDHHS/0,1607,7-132-2945\\_5102-14983--,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2945_5102-14983--,00.html)
12. Pregnancy Testing Centers (family planning clinics, crisis pregnancy centers)
13. Affordable Care Act Local Helpers  
<https://healthcare.gov>  
Click on “Find Local Help” at bottom of screen. Enter zip code for your service area to get a list of agencies that are assisting people to file Health Insurance Marketplace applications.
14. Community Action Agencies  
[www.mcaaa.org](http://www.mcaaa.org)
15. Emergency food, shelter, utility programs
16. Places of worship
17. Grocery stores
18. Dollar stores
19. Thrift stores (Goodwill, Salvation Army, Volunteers of America, etc.)
20. Laundromats
21. Beauty salons

Occasionally, a new MIHP provider will encounter difficulties in recruiting beneficiaries. In this case, contact your MIHP consultant.

### **MIHP Marketing and Outreach Development and Documentation**

MIHP providers must demonstrate a capacity to conduct outreach activities to the target population and to medical care providers in the geographic areas to be served. MIHP providers must develop and maintain on file a protocol which describes an outreach plan that specifies outreach activities, frequency of outreach activities and groups/agencies selected for outreach, including potential beneficiaries, medical care providers and other community providers who serve MIHP-eligible Medicaid beneficiaries.

Documentation must be maintained to indicate that outreach activities are being conducted according to plan, unless beneficiary referrals are received from a single, regular source.

### **Responding to Referrals Promptly**

The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs as specified below:

1. The provider must contact a pregnant beneficiary within 14 calendar days from the date the referral is received.
2. When an infant referral is received from a hospital prior to the infant's discharge, the provider is to complete the infant assessment visit within a maximum of two business days from the date of discharge.
3. When an infant referral is received from a source other than a hospital, the MIHP provider must respond to the referral within seven calendar days from the date the referral is received.

If the MIHP provider is unable to visit the beneficiary within the stated time frames, documentation must clearly support all attempts to contact or visit the beneficiary.

### **Replying to Referral Sources on the Status of Referrals Made to MIHP**

The *MIHP-MHP Communication Tool* has been developed for use by both MHPs and MIHPs to share information about mutually-enrolled beneficiaries on a monthly basis. The form can be generated by the MHP or the MIHP. This form replaces the *MIHP-MHP Referral Status Report Form*. The form and instructions for its use are available at the MIHP website.

MIHP providers are encouraged to document and report the status of a referral (i.e., initiation of services, inability to locate, or refusal of services) to other referral sources as well. The referral source may be a WIC office, medical care provider, community services agency, or other entity. Reporting the disposition of a referral assures the referral source that the beneficiary has not been lost in the system and is a basic professional courtesy. There is no form for MIHP providers to use to report disposition of referrals to referral sources other than MHPs. However, it is suggested these reports be written rather than verbal.

### **Replying to Referrals from Children's Protective Services**

When a provider receives a referral from Children's Protective Services (CPS), the provider must determine if the beneficiary is already enrolled in another MIHP. If so, the MIHP Agency must inform CPS that the beneficiary is currently being served by another MIHP agency and provide contact information for that agency. CPS cannot require a beneficiary to enroll in a *particular* MIHP. The beneficiary always has the right to decide whether or not to enroll in MIHP and to be served by the MIHP agency of her choice within her MHP network.

### **Making Referrals to Child Protective Services**

Monitoring the health and development of the infant is an important aspect of MIHP, and providers are required to observe the infant during every professional visit. When providers see signs of suspected abuse or neglect, they are obligated by law to make a referral to Children's Protective Services (CPS). MIHP must report possible child abuse or neglect to CPS in compliance with the Michigan Child Protection Law (Public Act 238 of 1975) by immediately calling Centralized Intake for Abuse and Neglect at 855-444-3911 and submitting a written report (DHS 3200) within 72 hours of the call.

Information about how to report suspected child abuse or neglect to CPS is available at the Michigan Department of Health and Human Services web site at [http://www.michigan.gov/dhs/0,1607,7-124-5452\\_7119---,00.html](http://www.michigan.gov/dhs/0,1607,7-124-5452_7119---,00.html)

Families that become involved with CPS may become eligible to receive a wide variety of services intended to improve their ability to care for their children, such as parenting classes, counseling, substance abuse treatment, medical services, anger management education, and other services designed to meet the family's specific needs, including MIHP.

The MIHP provider should maintain a relationship with CPS in every county they serve. All MIHP staff must be familiar with the provider's CPS reporting protocol.

### **CPS Online Training for Mandated Reporters**

Click here to view a 14-minute video on Mandated Reporters: Helping Protect Michigan's Most Vulnerable <https://www.youtube.com/watch?v=qFrtr6ybHH8>. For questions about reporting a particular situation to CPS, call the Mandated Reporter Hotline at 877-277-2585.

### **When Consent Is and Isn't Needed to Communicate with CPS**

The Michigan Child Protection Law requires mandated reporters to immediately report suspected abuse or neglect of a child to MDHHS CPS Centralized Intake. Consent is not required in order to report suspected abuse or neglect to CPS or while a CPS investigation is either being conducted, or when a case is open for services. During an investigation, only share information that is valid to the current investigation. CPS will not subpoena you for information while the investigation is underway. CPS has 30 days to complete the investigation and make a disposition of the case.

If the case involves a CPS case or a foster care case (requiring ongoing MDHHS case management), MDHHS caseworkers may be asked for and should provide a copy of the MDHHS Authorization to Release Confidential Information (DHS-1555-CS) signed by the beneficiary, before the MIHP provides information to CPS.

### **Conducting Outreach Activities Professionally and Fairly**

While conducting outreach activities, the provider must be mindful that the needs and wants of the beneficiary always come first. Some MIHP providers, especially if they are operating in counties with many other MIHP providers, may feel they are competing for MIHP referrals. A few may go so far as to engage in questionable outreach activities that are not in keeping with policy and are not in the best interest of beneficiaries.

MDHHS expects all MIHP providers to conduct their outreach activities professionally, fairly, and ethically. This includes, but is not limited to, the following:

1. Not offering incentives (e.g., diapers, Pack N Plays, gift cards, etc.) to encourage beneficiaries to enroll in MIHP
2. Not using false advertising
3. Not promising more than can be delivered
4. Not entering a beneficiary's name in the MIHP database as a placeholder
5. Refraining from seeing beneficiaries who are already being seen by other MIHP providers
6. Sharing information with other providers as appropriate

MIHP providers are expected **not to advertise or use in promotional activity, a promise to provide any free items or services** to beneficiaries. Local organizations sometimes sponsor community baby showers or health fairs and ask participating agencies to bring gifts to raffle off to participants. If participating in a community baby shower gifts for the raffle may be donated, but *Risk Identifiers* may not be administered there and the baby shower may not be used as a vehicle for MIHP enrollment in any way.

Providers are expected to comply with requirements issued by the Office of Inspector General (OIG) US Department of Health and Human Services in a special advisory bulletin titled *Offering Gifts and Other Inducements to Beneficiaries*, August 2002. Providers who do not comply with the requirements specified in this bulletin may be dis-enrolled from Medicaid/MDHHS programs. The bulletin is available at [Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries](#).

### **Filing a Complaint against Another MIHP Provider**

If an MIHP provider feels that another MIHP provider is consistently conducting outreach activities in an unprofessional, unfair, or unethical manner, or is otherwise acting inappropriately, the provider is encouraged to complete an *MIHP Complaint Form* and submit it to MDHHS. The form is at the MIHP website. In consultation with the MDHHS Perinatal Health Unit Manager, the complaint will be investigated by the MIHP Quality Improvement Coordinator. If it is found that a provider is, in fact, operating unprofessionally or unfairly, the provider will be required to implement a corrective action plan.

### **Employee Complaints against MIHP Providers**

The MDHHS Perinatal Health Unit does not investigate complaints made by MIHP employees against their employers. Employees with personnel issues (e.g., wage disputes, alleged discrimination, abusive practices, etc.) that are not resolved through the MIHP's internal employee grievance procedure, are encouraged to view the Michigan Department of Licensing and Regulatory Affairs (LARA) website at [www.michigan.gov/lara](http://www.michigan.gov/lara) for information on possible courses of action. Employees with concerns other than personnel practices are referred to *Chapter 13 – Reporting Medicaid Billing Fraud, HIPAA Violations, and Quality of Care Concerns*.

### **Helping Potential MIHP Beneficiaries to Apply for Medicaid and Maternity Outpatient Medical Services (MOMS)**

Many MIHP beneficiaries who are identified through outreach are not enrolled in Medicaid (and so are not in MHPs) when MIHP services are initiated. MIHP providers cannot be reimbursed for services provided to a woman until she has applied for Medicaid, been approved, and received a Medicaid ID number.

However, if the woman enrolls in the Maternity Outpatient Medical Services (MOMS) Program at the time she applies for Medicaid, she is given a *Guarantee of Payment* letter. This letter is intended to assure providers that MDHHS will reimburse for pregnancy related services, including MIHP services, provided to the beneficiary. This letter includes information on eligibility, covered services, billing instructions, etc. A sample letter is available in the Forms Appendix of the *Medicaid Provider Manual*.

Women applying for Healthy Kids for Pregnant Women Medicaid must request a presumptive eligibility determination if they want to receive prenatal services prior to receiving a Medicaid number. Healthy

Kids for Pregnant Women applicants will receive prenatal services only under their presumptive eligibility. MIHP is considered a part of the prenatal services.

While MIHP providers are not paid for assisting women to apply for Medicaid and MOMS, it is clearly to their advantage to do what they can to facilitate the submission of these applications. They may do this by helping a woman to complete an online or paper Medicaid application or referring her to the Michigan Health Care Helpline at (1-855-789-5610) or [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) for application assistance.

### **Filing a Medicaid Application**

Medicaid applications are submitted to and processed by the Michigan Department of Health and Human Services (MDHHS). If a Medicaid application is filed online, a statement is issued verifying the application date and if requested, presumptive eligibility. This statement is proof of the date that MDHHS received the application. The MDHHS standard of promptness to approve or deny a Medicaid application for a pregnant woman is 15 calendar days. The beneficiary's Medicaid ID number is issued at the time her application is approved.

### **Local Health Department Medicaid Outreach Activities**

Assisting MIHP beneficiaries to enroll in Medicaid is not a covered MIHP service. However, local health departments (LHDs) are encouraged to conduct Medicaid outreach activities to assist Medicaid eligible individuals to access Medicaid-covered services and some LHDs perform this function. Medicaid outreach activities include informing families, parents and community members about the Medicaid program and assisting an individual or family to enroll. For more information, go to *Medicaid Provider Manual* at [Medicaid Provider Manual](#), click on "Local Health Departments" in the bookmarks column, and then go to Section 3 of that chapter.

### **Using the MIHP Logo for Outreach Purposes**

Samples of variations of the MIHP logo, the MIHP Logo Usage Guidelines and the MIHP Logo Permission Request Forms are available on the MIHP website.

All MIHP materials which display the MIHP logo must be approved by assigned MIHP consultant prior to use. To assure proper use of the logo, please review the MIHP Logo Usage Guidelines prior to requesting approval for using the MIHP logo.

The MIHP logo is available in black and white and in the original teal color, and it comes in various sizes. When submitting a logo permission request to assigned consultant, indicate which variation is being requested and the logo will be sent via email. Along with the permission request, include draft copies of any materials planned for use with the MIHP logo.

## SECTION 8 - MIHP SERVICE DELIVERY

### Conducting Professional Visits to Deliver Case Management and Health Education Services

MIHP services (except for transportation, childbirth education classes, and parenting education classes) are provided through one-on-one/dyad, face-to-face meetings, lasting at least 30 minutes. These meetings are referred to as professional visits. Professional visits are never conducted with groups of beneficiaries. The specific purpose of professional visits is to implement the *Plan of Care*, which is based on the beneficiary's *Risk Identifier* and professional observation and judgment.

### Individualized Services to Meet the Needs of Each Beneficiary

The way in which MIHP services are provided are standardized through an evidence based risk screener and plans of care. However, services must be individualized to meet the needs of each beneficiary. Some beneficiaries may have limited reading skills or information processing difficulties, some may not speak English, some may require accommodations due to physical or emotional challenges, some may require evening or weekend appointments due to work or school schedules. MIHP providers must do everything possible to meet these needs.

### MIHP Case Management Services

#### MIHP Case Manager\*

The nurse and the social worker jointly develop the beneficiary's plan of care after the licensed registered nurse or licensed social worker administers the *Maternal Risk Identifier* or the *Infant Risk Identifier*. At that time, either the nurse or the social worker is designated as the beneficiary's case manager. The registered dietitian and the infant mental health specialist cannot function as the case manager.

The name of the case manager must be documented in the beneficiary's record. If there is a change in case managers during the beneficiary's participation in MIHP, this also must be documented in the record.

The case manager is responsible for monitoring and coordinating all care provided for the beneficiary. This means that the case manager follows up with the other professionals or agencies who are working with the beneficiary to assure that the team is doing all of the following things:

1. Ensuring that the beneficiary is involved in her own care plan development and service arrangements to the greatest possible extent.
2. Using Motivational Interviewing and promoting self-empowerment and self-management.
3. Facilitating implementation of the *Plan of Care (POC)*; coordinating services when multiple providers are involved.
4. Helping the beneficiary to locate resources; facilitating connections with providers of other services and supports; advocating on behalf of the beneficiary to obtain services, if needed.

(NOTE: The team encourages the beneficiary to take as much responsibility as possible for arranging and accessing services for herself and her infant, in that learning to navigate the health care system is an important goal for all MIHP beneficiaries. Of course, the team offers hands-on support in arranging services for beneficiaries who clearly need it, for example, women with developmental challenges or who are immobilized with depression.)

5. Following up with the beneficiary to determine if she has connected with, and is actually receiving services from, a particular referral source; if not, assisting the beneficiary to address barriers.
6. Assisting the beneficiary with needs and problems as they arise.
7. Evaluating whether the *POC* is meeting the beneficiary's goals.
8. Modifying the *POC*, as needed.
9. Communicating with medical care provider and Medicaid Health Plan.
10. Determining if specified, desired service outcomes are achieved.

\*For purposes of documentation, list the name of the Case Manager on documents requiring the name of the Care Coordinator

### MIHP Process Overview

The MIHP process includes eight components. Some of these components can only be done by certain disciplines. The chart below shows which of the components can be done by which disciplines.

Process Component	Responsible Staff
1. Administration of <i>Risk Identifier</i> and completion of <i>Plan of Care, Part 1</i>	RN or SW; <i>POC 1</i> must be signed by the individual who administers the <i>RI</i> .
2. Development of <i>Plan of Care, Parts 2 – 3</i>	RN and SW; <i>POC 3</i> must be signed by both
3. Implementation of <i>Plan of Care, Part 2</i>	Two or more of the four disciplines
4. Documentation of visits	Two or more of the four disciplines
5. Monitoring implementation of <i>Plan of Care, Part 2</i>	Case Manager: RN or SW
6. Coordination with MHPs	Case Manager: RN or SW
7. Coordination with Medical Care Provider	Case Manager: RN or SW
8. Conclusion of MIHP services	Any one of the four disciplines may make the last visit. However, only the RN or SW can complete the <i>Discharge Summary</i>

### Case Management Tracking Forms\*

MIHP case management requires attention to many different details. Three forms are used to ensure that the case management activities are tracked and documented:

1. The *Maternal or Infant Forms Checklist* is required to track and document each component of the case management process from the date of receipt of referral to the date the *Discharge Summary* is sent to the medical care provider and the *Notice of MIHP Beneficiary Discharge* is sent to the MHP.
2. The *MIHP Contact Log* (or an alternative contact log of your own design) is required to:
  - a. Track and document attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) if there's a gap in service between professional visits and from the last professional visit to discharge.
  - b. Document the reason why visits are not conducted monthly (at least once in a given month).
  - c. Document the specific purpose that an infant case is being kept open after four consecutive months of inactivity.

The *Contact Log* is used for other purposes as well.

3. The *MIHP Referral Log* may be used to track and document referrals to other services and supports. MDHHS developed this form for providers to use as a worksheet. If MIHP providers choose to use the optional *MIHP Referral Log*, the referrals listed on the log must be transferred to the Professional Visit Progress Note (PVPN). It is required that all referrals are tracked on the PVPN.

\*For purposes of documentation, list the name of the Case Manager on documents requiring the name of the Care Coordinator

### MIHP Education Services

In addition to coordinating the beneficiary's care, the MIHP provider delivers or arranges for the delivery of a variety of education services. Education may be provided by a registered nurse (RN), a social worker (SW), an International Board Certified Lactation Consultant (IBCLC) who is also a licensed RN or SW, a registered dietitian (RD) or an infant mental health specialist (IMHS). Education services are provided as part of the implementation of the *POC Parts 1-2*.

### Consent: *MIHP Consent to Participate and MIHP Consent to Release Protected Health Information*

#### Obtaining Consents Prior to Administering the *Risk Identifier*

A new, separate *MIHP Consent to Participate in Risk Identifier/MIHP Consent to Participate in MIHP* and a new, separate *MIHP Consent to Release Protected Health Information* is required for each individual beneficiary prior to administration of the *Risk Identifier*. Individual consents are required for multiples. Instructions on completion of both consent forms are posted at the MIHP website.

If a potential beneficiary declines to sign both consent forms, the *Risk Identifier* is not administered and no MIHP services are provided. The woman is given program contact information, in case she changes her mind. She also should be given the *MIHP Parent Information Sheet* or your own program materials and the entire *MIHP Maternal and Infant Education Packet* or information about signing up for text4baby.

If the beneficiary signs the *Consent to Participate in the Risk Identifier/Consent to Participate in MIHP*, but declines to sign the *Consent to Release Protected Health Information*, you may still provide services for her. When she signs the *Consent to Participate in the Risk Identifier/Consent to Participate in MIHP*,

the beneficiary is authorizing data entry into the MILogin System because MILogin is part of MDHHS. It is not a separate entity that would require a signed *Consent to Release Protected Health Information (PHI)* form.

If your agency has an in-house release, you are still required to use the MIHP release forms. If you have an agency release form that lists different agencies and medical care providers, you will need to list them again on the *MIHP Consent to Release PHI* form. If you need more lines, you may attach an additional page.

If a *Risk Identifier* is administered and the beneficiary initially declines to participate in MIHP (checks the “I do not wish to participate” box on the *Consent*), but then she changes her mind, use a new consent form.

If a consent needs to be modified, you have two choices. You may add entries to the original consent and have the beneficiary initial and date these modifications, or you may initiate a new consent. If there is more than one consent, keep all copies in the beneficiary’s chart.

## **Psychosocial and Nutritional Assessment Tools: *MIHP Risk Identifiers***

### **Risk Identifier Required Prior to Providing MIHP Services**

Medicaid requires that a psychosocial and nutritional assessment is completed before the beneficiary’s *POC* is developed and before she receives any type of MIHP service. The *Maternal and Infant Risk Identifiers* are the MIHP psychosocial and nutritional assessment tools.

The *Risk Identifier* must be administered, the *POC 1* must be completed, and the *Risk Identifier* data must be entered into the MDHHS database before the *Plan of Care (POC)*, *Parts 2-3* are developed and before any professional visits or other services (transportation, childbirth education classes, parenting education classes) can be provided, unless there is a documented emergency.

There’s a single exception to the requirement that the *Risk Identifier* must be administered before services can be provided, other than in an emergency situation. This exception is for Nurse-Family Partnership beneficiaries who may receive transportation services through MIHP.

The paper *Risk Identifier* functions as a worksheet only. The electronic version must be entered into the beneficiary’s paper or electronic chart before the first professional visit is conducted or any other MIHP services are provided.

You are not required to have developed the *POC Parts 2 and 3* before notifying the medical care provider and MHP that the beneficiary has enrolled in MIHP. You must notify the medical care provider and MHP of enrollment within 14 days of the *Risk Identifier* being fully administered.

If it takes two visits to fully administer the *Risk Identifier*, the second visit must take place within 14 calendar days from the date of the first visit.

### **When Multiple Providers are Working to Enroll the Same Beneficiary**

There may be times when multiple providers are working to enroll the same beneficiary in their respective MIHPs. When this happens, the provider that first enters the *Risk Identifier* data into the

MIHP database and obtains a *Score Summary* is the one that is authorized to serve the beneficiary and receive payment for the *Risk Identifier* visit.

### **Administering the *Risk Identifier* with Primary Caregiver**

Most often, the *Infant Risk Identifier* is done with the infant's biological mother. However, if the biological mother is not the infant's primary caregiver, the *Risk Identifier* is done with the individual who is functioning as the primary caregiver.

If the primary caregiver is not the mother, certain sections of the *Infant Risk Identifier* are not completed. *The Infant Risk Identifier - Maternal Component* has a checkbox to indicate that the primary caregiver is not the mother. When this box is checked, the questions that aren't pertinent to anyone but the biological mother are not asked. For example, a foster parent will not be asked questions that do not pertain to her.

### **When to Administer the *Infant Risk Identifier***

Administer the *Infant Risk Identifier* as soon after birth as possible. If you have been serving the infant's mother prenatally, do not wait until her MIHP postpartum visit is completed before you administer the *Infant Risk Identifier*.

### **Administering the *Risk Identifiers***

The *Maternal Risk Identifier* is the MIHP tool used to determine specific determinants of health and risks of pregnant women. The *Infant Risk Identifier* is the MIHP tool used to determine specific determinants of health and risks of infants and their primary caregivers.

The *Risk Identifiers* do **not** address every conceivable risk to maternal and infant health. The goal of the *Risk Identifier* is to identify health factors and risks that are **clearly** linked to poor birth outcomes **and** for which there are interventions that have proven successful (or are considered promising practices) in reducing those risks. Only risks that meet both of these criteria are included in the *Risk Identifiers*, which supports the MIHP as an evidence-based model.

Each question must be asked on the *Risk Identifier*, however the beneficiary may not be comfortable answering all of the questions. The timing of asking sensitive questions, such as those pertaining to domestic violence or drug misuse, should be a consideration. If the beneficiary chooses not to respond to specific questions initially, the MIHP staff should ask the questions at a later visit and document the beneficiary's response on a *Professional Visit Progress Note*.

### **Establishing Rapport at *Risk Identifier* Visit**

During the enrollment visit with the pregnant beneficiary or primary caregiver, establishing rapport is imperative, as this will increase the likelihood that the beneficiary will want to stay in the program. Professional staff must be knowledgeable and understand the risk identifier before administering it. Knowledge of the tool helps the professional become more comfortable asking questions which can put the beneficiary more at ease. Explain the tool before administering it so the beneficiary knows what to expect. By being aware of the assessment questions; being an active listener; and being respectful, you can elicit meaningful responses from the beneficiary or primary caregiver. All of these techniques can assist in establishing rapport with the beneficiary and their family.

**If a Woman Declines MIHP Services before or after *Maternal Risk Identifier* Administered**

If a woman declines MIHP services before or after the *Maternal Risk Identifier* has been administered, she should be asked if the provider may contact her again around the time that the baby is due to see if she would like services at that time. If she says yes, the provider should use a tickler file to ensure that a staff re-contacts the woman at that time. If a mother declines services for her infant before or after the *Infant Risk Identifier* has been administered, she should be asked if the provider may contact her a few months later to see if she would like MIHP services at that time. In the comments section of the *Risk Identifier*, document that you gave the woman the entire *MIHP Maternal and Infant Education Packet*.

When a woman declines services after the *Risk Identifier* is administered, do not develop the *POC Parts 1, 2 and 3*. However, be sure to complete the *Discharge Summary*.

**Data Entry and Scoring Results Page**

After the *Risk Identifier* is administered, the responses are entered in the MDHHS MIHP database. All responses, except for the Medicaid ID number, must be entered into the database in order to get a *Score Summary* printout. The *Maternal Risk Identifier Score Summary* printout indicates the pregnant woman's level of risk for each maternal domain and her overall risk score. The *Infant Risk Identifier Score Summary* printout indicates the infant's level of risk for each infant domain and his overall risk score, as well as the mother's level of risk for each maternal domain and her overall risk score.

Each domain scores out at one of the following risk levels: no, low, moderate, high or unknown. Not all of these risk levels are available as options in all domains. "Unknown" is used when the potentially high risk questions regarding a specific domain are not answered by the beneficiary. These include specific questions regarding previous poor birth outcomes, alcohol or drug misuse, abuse/violence, stress/depression/mental health, and family planning. If a specific domain scores out as "unknown", implement the highest risk level interventions available for that domain, not including the emergency level interventions.

The overall score is determined as follows:

<b>No Risk:</b>	If no domain has a high, moderate or low score and no unknown or refused responses were given
<b>Low Risk:</b>	If no domain has a high or moderate score and no unknown or refused responses were given
<b>Moderate Risk:</b>	If no domain has a high score and at least one domain has a moderate score and no unknown or refused responses were given
<b>High Risk:</b>	If any domain has a high score
<b>Unknown Risk:</b>	If no domain has a high score and at least one unknown or refused response was given to the high-risk questions

The first professional visit should take place within 30 days of MIHP enrollment (date that the *Risk Identifier* was fully administered). If you are not able to connect with the beneficiary within 30 days of the *Risk Identifier* visit but you intend to keep trying, document this on the *Contact Log*.

**Step-by-Step Implementation of the MIHP Case Management and Health Education Services**

MIHP providers strive to identify and enroll women in MIHP as early in their pregnancies as possible. Research has shown that outcomes are better if a pregnant woman enrolls in MIHP in her first or second trimester. However, some women are not identified and enrolled in MIHP while they are pregnant. Their infants may be enrolled in MIHP after hospital discharge or at any other time during infancy up to

12 months of age. After the birth of the infant, the MIHP provider works with the infant's primary caregiver. Most often, this is the infant's mother. However, if the mother is not the infant's primary caregiver, the MIHP provider may visit with another individual who is serving in this capacity.

### **Differences between MIHP Prenatal and Infant Services**

The provider can render services to the pregnant woman in order to complete the beneficiary's *Plan of Care* until the first visit post-partum or MIHP eligibility ends. There are 9 visits available during the prenatal and postpartum period. There are 9 visits available during infancy. In infancy however, after the first 9 visits are completed, an additional 9 visits may be provided in order to meet the *POC* objectives, if authorized by either the infant's medical care provider or a standing order signed by a medical care provider. A total of 36 visits may be provided for drug-exposed infants, if authorized by the either the infant's medical care provider or a standing order signed by a medical care provider. During the entire time that the pregnant or infant beneficiary is receiving MIHP services, appropriate referrals should be made and all beneficiary questions should be answered.

MIHP case management and health education services activities during the pregnancy and infancy phases are essentially the same, but there are some differences. For example, the required forms, while similar, do not contain all of the same information and questions, and educational interventions vary somewhat.

Another difference is that during the infancy phase, ongoing developmental screening is provided for all MIHP-enrolled infant beneficiaries. This is because infancy is a time of dynamic change across developmental domains (communication, gross motor, fine motor, problem-solving, social and emotional) and an infant's status may change in a surprisingly short period of time. Unless ongoing developmental screenings are conducted, early identification of concerns may not occur, and necessary referrals, support and treatment may not be provided for the infant. The case manager provides support and education to the infant's primary caregiver/family to help them understand the need to monitor the infant's health, safety and development.

### **MIHP Service Delivery Tasks by Case Management Component**

Below is an outline of tasks that are to be performed by the MIHP provider when a woman enrolls in MIHP while she is pregnant or after her baby is born, whether or not she participated in MIHP during her pregnancy. These tasks are classified under the following headings:

1. Risk Identification (Psychosocial and Nutritional Assessment)
2. *Plan of Care (POC)* Development
3. *Plan of Care* Implementation
4. MIHP Action Plan
5. MIHP Safety Plan
6. Documentation of Visits
7. *Plan of Care* Implementation Monitoring
8. Coordination with Medicaid Health Plans
9. Coordination with Medical Care Provider
10. Conclusion of MIHP Services

#### **1. Risk Identification (Psychosocial and Nutritional Assessment)**

- a. Upon receipt of a referral to your MIHP, verify the correct spelling of the beneficiary's name in CHAMPS, if she is enrolled in Medicaid.

- b. Determine if another provider has already done a *Risk Identifier* for the referred individual. Do this by using the “check for existing screens” function of the MDHHS MIHP electronic database. Always search by name and date of birth first, and then by Medicaid number. Search for an existing *Maternal Risk Identifier* and *Infant Risk Identifier* under the mother’s name and date of birth when you get an infant referral. When you select the “check for existing screens” function, instructions are provided. If another provider has done a *Risk Identifier*, do not do another one. Never open a maternal or an infant case without checking to see if beneficiary is already being served by another provider.

If the potential maternal or infant MIHP beneficiary is identified through outreach (e.g., at WIC office, local MDHHS office, OB clinic, hospital, pediatric clinic, etc.), you still need to determine if the beneficiary is already involved with another MIHP provider by using the database “check for existing screens” function.

If you find that a beneficiary is enrolled in another MIHP, encourage her to stay with her current MIHP provider, if possible. If she chooses to transfer to your program, ask her to sign a *Consent to Transfer MIHP Record to a Different Provider (Consent to Release Protected Health Information)* and obtain her information from the other provider. Do not administer another *Risk Identifier*.

- c. Never enter a beneficiary’s name into the database as a placeholder; you are NOT allowed to claim that you are serving a potential beneficiary before you obtain consents and administer the *Risk Identifier*.
- d. Meet individually, face-to-face with the potential MIHP beneficiary or beneficiary’s primary caregiver.
  - 1) Carefully explain MIHP. You may give the beneficiary the *MIHP Parent Information Sheet* or your own program materials, but don’t expect that this will provide a sufficient explanation. One of the reasons women give for dropping out of home visiting programs is that they didn’t understand why the home visitor was really there or didn’t see how the home visitor could actually help them. You may need to explain MIHP more than once at the *Risk Identifier* visit.
  - 2) Ask if the beneficiary needs assistance to apply for Medicaid for herself or infant if not already covered, as described below:
    - a) If a pregnant woman is not a Medicaid beneficiary, help her to apply for Medicaid and MOMS online or to complete the paper application form. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage her to select a Medicaid Health Plan (MHP) as soon as she receives notice that her Medicaid application has been approved (rather than wait an additional 30 days to be automatically assigned). The legal standard of promptness requires MDHHS to process a pregnant woman’s Medicaid application within 15 days from the date of submission.
    - b) If a woman with an infant was a Medicaid beneficiary while she was pregnant (coverage continues during the month her pregnancy ends and during the two calendar months following the month her pregnancy ends), encourage her to inform MDHHS of the baby’s birth immediately, so that MDHHS can issue the infant a Medicaid ID number. If the mother is in an MHP at the time of the birth of her baby, the baby will be enrolled in that

plan for at least the birth month. The family could prospectively choose a different MHP for the infant.

- c) If the woman was not a Medicaid beneficiary while she was pregnant and her infant is not a Medicaid beneficiary, help her to complete an online or paper Medicaid application on behalf of her infant. Alternatively, you may refer her to [www.Michigan.gov/mibridges](http://www.Michigan.gov/mibridges) or the Michigan Health Care Helpline at (1-855-789-5610) for application assistance. Encourage the mother to enroll the infant in an MHP as soon as she receives notice that the infant's Medicaid application has been approved (rather than wait the 30 days to be automatically assigned). Do not open an MIHP case, as no billable service has been provided.

It may take up to two months for MDHHS to provide the infant's Medicaid ID number. Presumptive eligibility letters are not issued for infants, as they are for pregnant women. However, if the mother was an enrolled Medicaid beneficiary at the time of the infant's birth, it is likely that the infant will be Medicaid eligible. If the infant does qualify, claims may be submitted retroactively to birth.

- 3) Carefully explain the *Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP* form and obtain beneficiary's signature. The potential beneficiary, or the primary caregiver if the beneficiary is an infant, must print and sign her name on this form before you can administer the *Risk Identifier* and enroll her in MIHP.
- 4) If the potential beneficiary **declines** to sign the *Consent to Participate in the MIHP Risk Identifier Interview/Consent to Participate in MIHP*, you do not administer the *Risk Identifier* and she is not eligible to receive any MIHP services, including child birth education classes, parenting classes or transportation. Proceed as follows:
  - a) Give her your program contact information in case she changes her mind. Provide her with the *MIHP Parent Information Sheet* or your own program materials and the entire *MIHP Maternal and Infant Education Packet* or tell her how to sign up for *text4baby*. Ask if you may contact her near her due date to see if services are needed at that point. If the potential beneficiary is an infant, ask the primary caregiver if you may contact her in a few months to see if services are needed at that point.
  - b) If a potential beneficiary who declines to participate in MIHP was referred by her MHP, you must notify her MHP that she has declined MIHP, using the *MIHP-MHP Communication Tool*. If she was not referred by her MHP, you are not required to inform the MHP, but you may choose to do so.
- 5) If the beneficiary **agrees** to sign the *Consent to Participate in MIHP Risk Identifier Interview/Consent to Participate in MIHP*, proceed as follows:
  - a) Explain the *MIHP Consent to Release Protected Health Information*. Complete the form with her, and ask her to print and sign her name on the form.
  - b) Administer either the *Maternal Risk Identifier* or the *Infant Risk Identifier*. The *Risk Identifier* is the MIHP psychosocial and nutritional assessment form.
- 6) If the beneficiary **agrees** to participate in MIHP services after the *Risk Identifier* has been administered:
  - a) After completing the *Risk Identifier*, give the beneficiary or the beneficiary's primary caregiver the *MIHP Parent Information Sheet* or your own program materials and the entire *MIHP Maternal and Infant Education Packet* (do not

split it into maternal and infant packets and hand them out separately) and/or assist her to sign up for *text4baby*. Providing the *Education Packet* and/or *text4baby* is part of the *Risk Identifier* visit. At future visits, you will review the packet materials with her, as needed. Of course there is the possibility that you will need to replace the packet or components that you find necessary, if she doesn't keep the packet. You need to document that she signed up for *text4baby*, if that was her choice, on the *POC 1*.

- b) Give the beneficiary or the beneficiary's primary caregiver a copy of your internal beneficiary grievance procedure and a copy of *Your Rights and Responsibilities as a Maternal Infant Health Program Participant*. You may copy these two documents back to back. If the beneficiary is an MHP member, she also has access to the MHP's complaint process, described in the *MHP Member Handbook*. This process can be used to voice complaints or concerns about her health care or health care provider, including her MIHP.
  - c) Complete each of the tasks listed on the *Plan of Care, Part 1*. If the beneficiary has an emergency situation, you can assist her to deal with the crisis before doing the *POC, Part 1*.
  - d) If you have time after you administer the *Risk Identifier*, you may address some of the topics from the *MIHP Maternal and Infant Education Packet* or *text4baby*.
- 7) If the beneficiary **declines** MIHP services after the *Risk Identifier* has been administered:
- a) Give her your program contact information in case she changes her mind. Provide her with the *MIHP Parent Information Sheet* or your own program materials and the entire *MIHP Maternal and Infant Education Packet* and/or tell her how to sign up for *text4baby*. Ask if you may contact her near her due date to see if services are needed at that point. If the potential beneficiary is an infant, ask the primary caregiver if you may contact her in a few months to see if services are needed at that point.
  - b) If a potential beneficiary who declines to participate in MIHP was referred by her MHP, you must notify her MHP that she has declined MIHP, using the *MIHP-MHP Referral and Communication Tool*. If she was not referred by her MHP, you are not required to inform the MHP, but you may choose to do so.
- 8) If a woman **declines** or **accepts** services after the *Risk Identifier* is administered:
- a) Enter *Risk Identifier* data into the MIHP electronic database. (NOTE: Do not enter **any** data into the database until the beneficiary has signed the *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and the *Consent to Release Protected Health Information* and the *Risk Identifier* has been administered.)

Upon completion of data entry, a computer-scored *Score Summary* is provided. All responses, except for Medicaid ID number, must be entered into the database in order to get the *Score Summary* printout. The maternal *Score Summary* includes: 1) the beneficiary's risk factors, stratified into no, low, moderate, high or unknown risk levels, and 2) a determination of overall risk level. The infant *Score Summary* includes: 1) the infant's and mother's risk factors, stratified into no, low, moderate, high or unknown risk-levels, and 2) a determination of overall risk level for each beneficiary.

- b) You can enter the *Maternal or Infant Risk Identifier* data and get the *Score Summary* printout before you have the beneficiary's Medicaid ID number. However, in order to complete the *Risk Identifier*, you must go back and enter the ID number when you get it. You may not bill for the *Risk Identifier* until you have completed the *Risk Identifier*, entered the *Risk Identifier* data into the database (with the Medicaid ID number), and developed the *POC Parts 1, 2, and 3*. The *Risk Identifier* is considered complete when data has been entered into all required fields, including the Medicaid ID number.  
The only exception to this is when the beneficiary declines MIHP services after the *Risk Identifier* is administered. In this case, do not develop the *POC Parts 1-3*. However, you must complete the *Discharge Summary*.
- c) You may bill for administering the *Risk Identifier*, even if the beneficiary declines services. If a potential beneficiary agrees to participate in the *Risk Identifier* interview but does not agree to participate in MIHP, you complete the *Risk Identifier* interview, enter her data into the MIHP electronic database, and complete a *Discharge Summary*. You can bill for the completed *Risk Identifier* only after her *Risk Identifier* data has been entered into the MIHP electronic database.
- d) It is essential that you enter the beneficiary's Medicaid ID number as soon as you receive it.
- e) On occasion, you may need to make a correction to a record in the MIHP database (*Risk Identifier* or *Discharge Summary*). You can correct any errors in the *Maternal Risk Identifier* or *Infant Risk Identifier* within 30 days of completion as long as you have not started a *Discharge Summary*. If it's beyond 30 days or you have started a *Discharge Summary*, you must request that MDHHS delete the *Risk Identifier* from the database and then you must re-enter all of the data. Use the *MIHP Database Record Revision Request Form* for this purpose. The form and instructions on how to complete it are at the MIHP website. Document a re-entered *Risk Identifier* by keeping the previous version, along with *MIHP Database Record Revision Request Form*, in the chart. If the *Risk Identifier* has been re-entered more than once, keep all previous versions in the chart.
- f) File the electronic *Risk Identifier* and the *Risk Identifier Score Summary* in the beneficiary's chart before the first professional visit is conducted or any other MIHP services are provided. It's expected that all professional staff have access to the total chart and will read the entire *Risk Identifier* printout, not just the *Score Summary*, in order to get a comprehensive understanding of the beneficiary's risks and circumstances.
- g) If you complete a *Risk Identifier* for a pregnant woman but she is not approved for Medicaid, delete it from the database if it's within 120 days from the date you printed out the *Risk Identifier Score Summary*. If you experience any difficulties, contact MDHHS.
- h) If you implement one or more *POC 2* interventions at the time of the *Risk Identifier* visit, document this on the appropriate *POC 2* domain, noting the "Date 1<sup>st</sup> Addressed." You may also document interventions provided before the official development of the *POC 2* on a *Professional Visit Progress Note* or *Contact Log*. If the domain subsequently doesn't score out as a risk on the *Risk*

*Identifier* summary, you can identify it as a risk based on professional observation and judgment, if the criteria in Column 2 are met.

- i) If you make a referral during the *Risk Identifier* visit, document it on the *POC 1* and also on the *POC 2* if the referral was a *POC 2* intervention
- j) There is not a specific box or space on the *Risk Identifier* to enter the location of the beneficiary's medical care provider. You can add this information to the comment section of the *Risk Identifier* or to your own form.

## 2. Plan of Care (POC) Development

The foundation of MIHP case management is the *Plan of Care (POC)*. The *POC* consists of three standardized forms:

*Maternal or Infant Plan of Care Part 1 (POC 1)*

*Maternal or Infant Plan of Care Part 2, Interventions by Risk Level (POC 2)*

*Plan of Care Part 3, Signature Page for Interventions by Risk Level (POC 3)*

### **Plan of Care, Part One (POC 1)**

The *Maternal POC 1* or the *Infant POC 1* is completed for all beneficiaries after the *Risk Identifier* is administered, unless the beneficiary has declined to participate in MIHP. The *POC 1* documents that the professional (RN or SW) has completed the following tasks at the time of the *Risk Identifier* visit:

1. Provided the beneficiary (pregnant woman or infant's primary caregiver) with the entire standardized *MIHP Maternal and Infant Education Packet*, which includes information about each of the MIHP risk domains, or assisted the beneficiary to sign up for *text4baby*, or both.  
NOTE: If the beneficiary chooses *text4baby* rather than the packet, the professional must follow-up at subsequent visits to ensure that beneficiary is receiving *text4baby* messages.
2. Provided an opportunity for the beneficiary to ask questions.
3. Provided the beneficiary with written information about the Healthy Michigan Plan.
4. Made a referral to WIC, if needed.
5. Prepared the beneficiary for further MIHP visits.
6. Provided the beneficiary with written information on how and when to contact the agency.
7. Provided the beneficiary with the agency's beneficiary grievance procedure in writing, along with *Your Rights and Responsibilities as a Maternal Infant Health Program Participant*.
8. Provided the beneficiary with the following:

#### **Pregnant beneficiary**

- Advice on how to access community-based no and low cost food programs.
- Assistance with identifying an emergency transportation plan.
- Assistance with identifying at least one individual to call when needed.

#### **Infant beneficiary's primary caregiver**

- Information about parenting classes and support groups available in the community
- Information about developmental screening using ASQ-3 and ASQ: SE-2 Questionnaires corresponding to the infant's age
- Advice on how to access community-based no and low cost food programs
- Assist with identifying an emergency transportation plan
- Assistance with identifying at least one individual to call when needed

9. Scheduled a follow-up appointment, or informed beneficiary that she will be contacted about this.

The *POC 1* must be completed, signed and dated by the RN or SW who administers the Risk Identifier. It is expected that in most instances, the professional who administers the *Risk Identifier* will sign the *POC 1* on the date of the *Risk Identifier* visit.

### **Plan of Care, Part Two (POC 2)**

MDHHS has developed a standardized set of *POC 2* interventions for pregnant beneficiaries and a standardized set of *POC 2* interventions for infant beneficiaries. The interventions are built on evidence-based, promising, and emerging practices identified in the literature, as well as best-practices. Various MIHP stakeholders, including MIHP providers and Medicaid, provided input as the interventions were developed.

MIHP providers are required to implement the standardized interventions, but it is expected that they will use professional observation and judgment as they do so. These are considered to be minimum interventions; providers can do more if they are in a position to do so.

### **Beneficiary with No Scored Risks**

Once the *Risk Identifier* data are entered into the MIHP database and the *Score Summary* printout becomes available, the nurse and social worker determine whether or not a *POC 2* is needed. If a beneficiary's *Risk Identifier* has no scored risk, a *POC 2* is not completed. Staff asks the beneficiary or legal representative if the MIHP may contact her again around the time that her baby is due or later in infancy to ask if she would like to participate in the program at that time.

Since all of the *MIHP Risk Identifier* questions are not included in the scoring algorithm, professional observation is essential to beneficiary assessment. On the rare occasion that there is no scored risk following the administration of the *Risk Identifier*, yet professional observation suggests the beneficiary would benefit from MIHP services, contact your MIHP consultant for authorization to provide MIHP services. If the consultant approves your request to serve the beneficiary, you will receive written authorization. The written authorization must be maintained in the beneficiary's chart and support how the beneficiary may benefit from MIHP services.

If the infant or mother has at least one risk identified on the *Infant Risk Identifier*, you do not need to request written authorization from your consultant in order to serve the dyad.

If the beneficiary states that she wants you to visit her even though no scored risks have been identified and professional observation does not indicate the need for MIHP services, contact your MIHP consultant and describe how the beneficiary may benefit from MIHP participation. Carefully document the reason and need for the visit. Once services are initiated, you may find that she meets risk criteria in one or more *POC 2* domains (e.g., social support, nutrition etc.) and you would then develop a *POC 2*. As you build rapport with the beneficiary, she may reveal other information indicating that she is at risk in additional domains as well.

The *Risk Identifier* and the *POC 1* must be completed and the *Risk Identifier* entered into the MIHP database before further MIHP services are initiated. Document your activities on the *Professional Visit Progress Note* under "other visit information."

Written approval from the consultant also is required when an agency requests permission to enroll an infant older than 12 months, zero days of age or to continue to serve an infant who has reached 18 months, zero days of age.

### Developing the *POC 2* for Beneficiaries with Scored Risks

The *POC 2* is developed for all beneficiaries with identified risks. If a beneficiary's *Risk Identifier* overall score is "low," "moderate," "high" or "unknown" risk, staff completes the *POC, Part 2*.

Before the *POC 2* is drafted, the professional who administers the *Risk Identifier* should talk with the beneficiary to get her input on her own problems, needs, goals, and objectives, so they can be clearly reflected in the *POC*. This is a crucial component of *POC 2* development. You may use *The Difference Game* (available from the MIHP state team) for this purpose.

The nurse and social worker must develop the *POC 2* together. The registered dietitian and infant mental health specialist may provide input into the *POC 2* development process.

A face-to-face conference is recommended, but not required, when developing the *POC 2*. Care conferencing by phone is acceptable. It is also acceptable for one party to draft the *POC 2* and leave it for another party to review and sign. The case manager is identified as the *POC 2* is developed.

### *POC 2* Domains

To develop the *POC 2*, the nurse and social worker use the standardized *Maternal or Infant Plan of Care Part 2, Interventions by Risk Level* forms to document the interventions that will be implemented with a particular beneficiary. Separate interventions are provided for risk domains covered in the *Maternal and Infant Risk Identifiers*. There are 16 maternal risk domains and 8 infant risk domains. This means that a maternal beneficiary's *POC 2* will consist of one to 16 domains and an infant beneficiary's *POC 2* will consist of one to eight domains, plus any applicable maternal domains, which are referred to as Maternal Considerations. *Plan of Care Part 2, Interventions by Risk Level* forms and instructions are available at [www.michigan.gov/mihp](http://www.michigan.gov/mihp).

There is no infant *POC 2* domain for birth health, although questions about it are included in the *Infant Risk Identifier*. Birth health is a static, one-time assessment and there are no interventions for it because we don't have the ability to change the status of an event that occurred in the past.

*POC 2* domains have low, moderate, high and emergency interventions. There are several domains that score out "unknown" if the beneficiary does not answer certain questions. These include specific questions regarding previous poor birth outcomes, alcohol or drug misuse, abuse/violence, stress/depression/mental health, and family planning. If a specific domain scores out as "unknown", implement the highest risk level interventions available for that domain, not including the emergency level interventions.

There is no requirement that the *POC 2* address a particular number of domains. Rather, a beneficiary's *POC 2* must incorporate all of the domains that correspond to her individual risks, as identified by the *Risk Identifier* or by the licensed registered nurse or licensed social worker, based on observation and information gathered during the initial interview. However, *POC* implementation is client-focused, meaning that the beneficiary may select the domains that are priorities for her and that she wishes to address.

### The POC 2 Domains and Completing the Forms

To compile the POC 2, the nurse and social worker place a POC 2 risk domain form (*Interventions by Risk Level*) for each of the beneficiary's identified risks, including those identified by the *Risk Identifier* and those identified by professional observation and judgment, in the beneficiary's chart. If you incorporate a domain based on professional observation and judgment, you need to document why you included the domain in the comments section on the *Risk Identifier*.

You cannot electronically override the computerized assessment results (*Risk Identifier* scores). In other words, you cannot change the risk level for any domain that scored out as a risk on the *Risk Identifier* as you develop the initial POC 2. However, you can add a domain based on professional judgment if the beneficiary meets the criteria designated in Column 1 (Risk Information). If you do add a domain before the initial POC 3 is signed, document the date that it was added on the POC 2 in the space provided in Column 1.

All of the *Maternal Plan of Care, Part 2 Interventions by Risk Level* and the *Infant Plan of Care, Part 2, Interventions by Risk Level* forms are divided into three columns: intervention level based on risk identifier; risk information; and intervention. Detail on completing these three columns is provided on the MIHP website.

There are three revised Maternal Plans of Care, Part 2 that will be used beginning January 1, 2018. Information regarding the revised plans of care are found on the MIHP website but are included below for your information.

#### **Column 1: Intervention level based on Risk Identifier, Date Risk Level Changed, and Risk Information**

- 1) Check the box that matches the risk level on the *Risk Identifier* Score Sheet.
- 2) A date is entered in the 'Date Risk Level Changed' for one of two reasons:
  - a) The Intervention Level was changed based on professional judgement
  - b) A new risk domain is added to the beneficiary's care
- 3) Check the box below the Intervention Level identifying the risk that corresponds to the intervention level if you are considering adding a domain or changing the risk level for an existing domain based on professional observation and judgment.
  - a) If the beneficiary's risk information matches the risk information criteria you can add a domain or change the risk level.
  - b) Document the reason for the Intervention Level change on the *Professional Visit Progress Note* or the *Contact Log*.

#### **Risk Information: Additional Considerations**

The Updated Plans of Care, Part 2 risk information aligns with the new *Maternal Risk Identifier* which has not been implemented program wide.

The most notable difference is the Tobacco POC2. For the Tobacco POC 2, MIHP providers will use professional judgement to identify the Intervention Level most appropriate for the beneficiary.

- 1) The current *Maternal Risk Identifier*
  - a) MODERATE risk only
    - i) Risk Information: Currently using tobacco and/or Exposure to 2<sup>nd</sup> hand tobacco smoke.

- 2) The new *Maternal Risk Identifier* and corresponding Tobacco POC 2
  - a) MODERATE risk
    - i) Risk Information: Previous tobacco use
  - AND**
  - b) HIGH risk
    - i) Risk Information: Currently using tobacco and/or exposure to 2<sup>nd</sup> or 3<sup>rd</sup> hand tobacco smoke.

If there is previous or current tobacco use by the beneficiary/caregiver, the Tobacco POC 2 must be pulled and implemented. Currently, there are no questions on the *Maternal Risk Identifier* addressing previous tobacco use.

It is highly recommended that MIHP providers ask about previous tobacco use to best serve the beneficiary and implement the appropriate interventions. If a domain scored out as “unknown,” check the highest level intervention box for that domain. There are several domains that score out as “unknown” if the beneficiary does not answer specific high-risk questions. These include previous poor birth outcomes, alcohol or drug use, abuse/violence, stress/depression, prenatal care and family planning.

#### **Column 2: Interventions and Date First Addressed**

- a) Interventions reflect evidence-based best practices
- b) MIHP providers are not required to implement all interventions
- c) MIHP providers are not required to implement interventions in number order, using professional judgement MIHP providers determine which interventions are most appropriate for a beneficiary
- d) Interventions are implemented at or below the beneficiary’s current documented Intervention Level
  - i) The electronic *Discharge Summary* will not allow MIHP providers to enter intervention numbers higher than the documented Intervention Level.
  - ii) If MIHP provider determines it is appropriate to implement higher level interventions, the Intervention Level must be changed.
- e) MIHP providers must input the date the intervention was first implemented in the section area next to the intervention number.

#### **Column 3: Resource – Referral – Communication**

MIHP providers must document the resources, referrals and communication made throughout the course of care.

##### **Resources**

- 1) Resources listed in Column 4 correspond to intervention numbers. The date under the ‘Date(s) Intervention Addressed’ should match the date under the resource
- 2) **MIHP Action Plan and MIHP Safety Plan**
  - The MIHP Action Plan and MIHP Safety Plan are new tools designed to increase collaboration between the MIHP provider and the beneficiary/caregiver being served.
  - Please see additional guidance on implementing the MIHP Action Plan and MIHP Safety Plan interventions on the MIHP website.

**Referrals****3) Medical Care Provider (PCP, OB/GYN, etc.)**

- MIHP providers' will check this box if they referred the beneficiary to their medical care provider for health recommendations, additional screening etc.

**4) Medicaid Health Plan (Case Manager, benefits etc.)**

- MIHP providers will check this box if they referred the beneficiary to their Medicaid Health Plan for additional assistance.

**Communication****5) MIHP Communication with Medical Care Provider**

- MIHP providers will check this box if the MIHP provider/staff communicated directly with the beneficiary's Medical Care Provider by means of a required MIHP communication or other form of communication (phone, fax, etc.)

**6) MIHP Communication with Medicaid Health Plan**

- MIHP providers will check this box if the MIHP provider/staff communicated directly with the beneficiary's Medicaid Health Plan by means of a required MIHP communication or other form of communication (phone, fax, etc.)

Detailed instructions for completing the *POC 2* are on the MIHP website.

***Plan of Care, Part Three (POC 3)***

*The Plan of Care, Part 3, Signature Page for Interventions by Risk Level* is a form used to document that the licensed social worker and registered nurse have jointly developed the *POC 2*, concur on the interventions to be implemented, and are responsible for implementation. The RN and SW must sign and date the *POC 3* within 10 business days of each other. This means that the *POC 3* can have different signature dates, but these dates must be within the 10-day limit. An additional signature line is provided for other disciplines contributing to *POC 2* development.

The *POC 2* and the *POC 3* must be completed and signed by the RN and SW before any professional visits are conducted or any other MIHP services are provided, unless there is a documented emergency.

**Changing the Risk Level after the *POC 2* is Developed and the *POC 3* is Signed**

After the *POC 2* is developed and signed, you may increase or decrease the risk level for a particular domain, but only if the beneficiary meets the criteria designated in the Risk Information area of the *POC 2* for that domain. For example, if the beneficiary scored moderate risk in a particular domain on the *Risk Identifier*, but you use professional judgment to determine that she meets the risk information criteria for high-risk, you would increase the risk level to high and use the high-risk interventions.

You can only document a risk level that has corresponding interventions for a particular *POC* domain. Document the date that you change the risk level in the *Date* space provided on the *POC 2*, and document the reason for the change in risk level on the *Professional Visit Progress Note* or *Contact Log*.

You cannot change the risk level during the case conference when the initial *POC 2* is developed. You must conduct at least one professional visit after the *Risk Identifier* visit to be able to change the risk level.

**Changing the Risk Level when Emergency Interventions are Implemented**

When the emergency interventions are implemented for a given risk domain, you must document this by changing the risk level on the *POC 2* or adding the *POC2* if this is a new risk. You must also notify the

medical care provider and the MHP that the emergency interventions were implemented. When the emergency is over, you must go back to the *POC 2* and decrease the risk level to the appropriate level.

### **Adding a New Risk Domain after the *POC 2* is Developed and the *POC 3* is Signed**

After the *POC 2* has been developed and the *POC 3* has been signed by the RN and SW, you may add a risk domain based on professional observation and judgment, but only if the beneficiary meets the criteria designated in Column 1 (Risk Information) of the *POC 2* for that domain. If you add a domain, document the date that it was added on the *POC 2* in the space provided and place it in the beneficiary's chart. Also, document the reason for adding the domain on the *Contact Log* or the *Professional Visit Progress Note*.

The RN and SW must update and sign the *POC 3*, documenting that a domain has been added. You must use the *Prenatal or Infant Care Communication/Notification of Change in Risk Factors Form* to inform the medical care provider and Medicaid Health Plan of this change.

If a new risk domain is identified at a professional visit, you may implement one or more interventions from that domain during the visit. When you return to the office, add the domain to the *POC 2* and update the *POC 3*.

### **3. Plan of Care Implementation**

*POC 2* implementation typically begins with the first professional visit after the *Risk Identifier* visit.

However, at times you may provide *POC 2* interventions at the *Risk Identifier* visit. If you do, document the *Risk Identifier* visit date in the "Date 1<sup>st</sup> Addressed" space on the appropriate *POC 2* domain page. You may also document interventions provided before the official development of the *POC 2* on a *Professional Visit Progress Note* or *Contact Log*.

Always check CHAMPS before you go out on a visit to determine if the beneficiary is currently enrolled in Medicaid, enrolled in a MHP or enrolled in an Integrated Care Organization. This can alert you to the fact that you may not be paid for the visit. Beneficiary eligibility and health plan enrollment status is available in CHAMPS.

Discussion of the *POC 2* with the beneficiary at the first professional visit should cover the *Risk Identifier* results and which domains the beneficiary chooses as her priorities. It is critical for her to see how her priority needs and goals are being incorporated in the *POC 2*. If she can't see "what's in it for me", she may drop out very quickly. Help the beneficiary to identify what will make a positive difference in her life. You may use *The Difference Game* (available from the MIHP state team) for this purpose.

Although the beneficiary or primary caregiver selects her own high-priority domains, this doesn't mean that you ignore her low-priority risk domains; in fact, you are required to bring up all of her risk domains at some point or to document why you did not do so on the *Professional Visit Progress Note* or *Contact Log*.

Use Motivational Interviewing techniques, respect the beneficiary's preferences, and gently encourage her to look at risk domains she is reluctant to address.

As you conduct visits to implement the *POC 2*:

- a. Be prepared for every visit. Staff must review the following before every visit:
  1. *Risk Identifier*
  2. CHAMPS (to determine Medicaid eligibility and if beneficiary has enrolled in an MHP since last visit)
  3. *POC 2*
  4. All *Professional Visit Progress Notes* to date
  5. Michigan Care Improvement Registry (MCIR) to check immunization status.
- b. Implement the interventions as specified in the *POC 2* for each domain. These are standardized interventions upon which the statewide MIHP evaluation is based; all MIHPs must essentially be implementing the same model in order for MIHP to be designated as evidence based. However, not all interventions will be applicable to all beneficiaries.
- c. Implement *POC 2* interventions only for risk domains that are included in the *POC 2*.
- d. If you identify a new risk domain during a professional visit, you may implement interventions from that domain on that same day, before you add the new domain to the *POC 2* and update the *POC 3*.
- e. Provide interventions during visits that reflect the *POC 2*.
- f. Provide interventions at or below the beneficiary's current documented level of risk. If you provide interventions above the beneficiary's documented level of risk for any domain, the electronic *Discharge Summary* will not record them in the "Interventions Provided" section. This means that the information will not be captured in the MIHP database at this time. In order to provide the most appropriate care, you should increase the risk level when the beneficiary's situation matches the risk information in Column 2 of the *POC 2*, so you can implement a higher level of interventions.
- g. Address all risk domains included in the *POC 2* or provide documentation as to why a risk domain is not being addressed on the *Professional Visit Progress Note* or *Contact Log*. Closed charts must indicate that staff addressed all risk domains or there must be documentation as to why risk domains were not addressed on the *Professional Visit Progress Note* or *Contact Log*.
- h. If the beneficiary signed up for text4baby, determine at subsequent visits whether or not she is actually receiving text4baby messages and document this on the *Professional Visit Progress Note*. If not, give her the entire *Maternal & Infant Education Packet*. Professional staff should always have an *Education Packet* with them, to be used in this instance or to supplement the information that the beneficiary is receiving from text4baby.
- i. Address all domains that score out as high risk within the first three visits or document why this has not been done on a *Professional Visit Progress Note*. For example, if the beneficiary is in an emergency situation such as imminent eviction, it's appropriate to address the emergency first. Be sure to document the reason why you did not address the high risk (e.g., depression) at one of the first three visits.
- j. Help the beneficiary develop a written or verbal safety plan when she scores out as high risk on the depression, domestic violence, or substance misuse domain, infant safety (infants only) or provide documentation that the beneficiary did not wish to develop a safety plan. See Safety plan form and instructions on the MIHP website.
- k. Refer beneficiary to other services and supports as specified in the *Plan of Care, Part 2, Interventions by Risk Level*. See *Referral Resources for MIHP Families* at [www.michigan.gov/mihip](http://www.michigan.gov/mihip). In MIHP, what it means to make a referral is specifically defined. See *Making and Following Up on Referrals* later in this chapter or at the MIHP website.
- l. Use Motivational Interviewing techniques throughout *POC 2* implementation.

- m. Coach the beneficiary to promote self-empowerment and self-management throughout *POC 2* implementation.
- n. Ask the beneficiary for feedback on services provided at the end of every visit.
- o. Spread out professional visits over the anticipated length of service, although much depends on the particular beneficiary's circumstances. While it is not appropriate to see beneficiaries every week as a standard practice, there may be rare circumstances that indicate the need for weekly visits. In these rare circumstances, be sure to document the reason why such frequent visits are indicated on the *Contact Log*.
- p. Consider administering the Adverse Childhood Experience (ACE) Questionnaire by the third professional visit for women with high risk.

### Implementing the Substance-Exposed Infant Interventions

There are three *Substance-Exposed Infant Plans of Care 2* (Positive at Birth, Primary Caregiver Use, and Environment). The substance-exposed infant interventions described in these Plans of Care are used when an infant is exposed to alcohol and/or other drugs by the primary caregiver, by others residing in or visiting the infant's home, or by others in another place where the infant spends a significant amount of time (e.g., a relative's home, a child care home, etc.).

If the mother scores out on the *Risk Identifier* for alcohol or drug misuse, or the Column 2 Criteria are met for one of the three *SEI Plans of Care*, pull the appropriate *SEI POC 2* and begin implementing the interventions **without delay**. MIHP professional staff **must** use the substance-exposed infant (SEI) interventions from the time a substance-exposed infant risk is identified.

If an SEI risk is identified during the period in which the first 18 professional infant visits are being conducted, bill the visits as standard professional visits (99402). When the 18 professional visits are exhausted but SEI needs persist, obtain authorization from the medical care provider for 18 additional visits and switch to the substance-exposed infant billing code.

For each substance-exposed infant visit (visits 19-36), you must:

1. Document the visit on the standard *Infant Professional Visit Progress Note*.
2. Address an SEI domain during that visit.
3. Use the substance-exposed infant (SEI) billing code (96154).

The SEI billing code, 96154, is billed in 15-minute increments. This means you must bill in units of two for a thirty-minute SEI visit. MIHP visits are required to be thirty (30) minutes at a minimum.

The additional 18 visits that are available to a substance-exposed infant are to be used before the infant turns 18 months of age. The intent is to visit the family more often, not to extend the period of MIHP services well into toddlerhood. Toddlers are not the expertise of the MIHP. When an infant turns 18 months of age, you must contact your consultant to request approval to continue to serve the infant.

For additional information:

- Refer to *Section 2.8 Drug Exposed Infant, MIHP Chapter, Medicaid Provider Manual*.
- See the MIHP website for the three *Substance Exposed Infant Plans of Care: Positive at Birth, Primary Caregiver Use, and Environmental Exposure*, along with instructions for completing them.
- See *Chapter 5 – Reimbursement for MIHP Services, MIHP Operations Guide*

## **Implementing Interventions in the Maternal Drugs and Substance-Exposed Infant Domains: Prescribed and Non-prescribed Medications**

For purposes of implementing the MIHP interventions related to drug misuse, drug misuse includes both prescribed and non-prescribed medications, including suboxone, methadone, subutex and marijuana. These medications have effects on fetal growth and development and could result in a positive drug screen and/or neonatal abstinence syndrome. Any infant exposed to these drugs is eligible for 18 additional substance-exposed infant visits, if authorized by the medical care provider.

### **4. MIHP Action Plan**

The MIHP Action Plan is a tool designed to enhance collaboration between the MIHP provider and the beneficiary being served. Utilizing motivational interviewing, MIHP providers will assist beneficiaries with creating a plan for something the beneficiary would like to change in their life. The MIHP Action Plan is listed as an intervention on the updated Tobacco, Alcohol and Substance Misuse POC 2s. MIHP providers will complete the MIHP Action Plan during a professional visit and it is recommended that a copy of the MIHP Action Plan be made for the chart and the original document be given to the beneficiary.

MIHP providers are required to have a completed copy of at least one MIHP Action Plan for each beneficiary. A completed copy is defined as a MIHP Action Plan with the “Goal(s)” section filled out.

Additional guidance on how to implement the MIHP Action Plan intervention is located on the MIHP website.

### **5. MIHP Safety Plan**

The MIHP Safety Plan is a tool to expand utilization of safety planning to all beneficiaries and standardize documentation. The beneficiary determines whether or not they want to keep a written copy of the MIHP Safety Plan. If the plan addresses depression or substance misuse, ideally they would keep it. However, it may not be safe for someone living in a domestic violence circumstance to have a written safety plan in the home.

It is recommended that MIHP providers have a completed copy of at least one MIHP Safety Plan for each beneficiary. A completed copy is defined as a MIHP Safety Plan with the ‘I am concerned about:’ section filled out.

The MIHP Safety Plan is not domain specific but is available as an intervention on the updated Tobacco, Alcohol and Substance Misuse POC 2s and developing a safety plan is **required** for the six below domains:

1. Stress/Depression Maternal  
High Risk #13: Develop and document emergency safety plan.
2. Abuse/Violence Maternal  
High Risk #14: Assist beneficiary with development of a personalized safety plan.
3. Substance Exposed Infant: Positive at Birth  
Moderate Risk #9: Assist with development of a safety plan to protect infant if /when Mom/Primary Caregiver is misusing drugs or alcohol.
4. Substance Exposed Infant: Primary Caregiver Use  
Moderate Risk #11: Encourage Caregiver to develop a Safety Plan.
5. Substance Exposed Infant: Environment  
High Risk #9: Assist with development of a safety plan to protect infant when others are using substances in the environment.

## 6. Infant Safety

High Risk #6: Assist with development of plan to address identified safety risk. This prompts you to develop specific safety plans geared toward the individual infant's particular safety risks (e.g., unsafe sleep practices, no car seat, drowning, etc.).

Document that the MIHP Safety Plan was developed by inserting the intervention number in the "Interventions Provided" field and describing the beneficiary's response in the "Narrative about Mother/Care Giver's Reaction to Intervention Provided" field on the *Professional Visit Progress Note*. If the beneficiary states that she does not wish to develop a safety plan, be sure to clearly document this and include the intervention number on the *Professional Visit Progress Note*, which indicates that you did address safety planning with the beneficiary.

Safety plans are discussed in three trainings on the MIHP website:

1. Implementing the MIHP Depression Interventions
2. Interpersonal Violence and MIHP
3. Intimate Partner Violence: More than Meets the Eye

Additional guidance on the utilization of the MIHP Safety Plan is on the MIHP website.

## 6. Documentation of Visits

A professional visit is a face-to-face encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) or registered dietician (with a medical provider order) for the specific purpose of implementing the beneficiary's plan of care. Documentation of MIHP services provided is required by Medicaid. Standardized forms must be used. Written instructions are available at the MIHP website to assist staff in completing the required data elements on all forms to assure that program services are appropriately recorded. For additional information on MIHP forms, see *Chapter 14 – Required MIHP Forms*.

The *Professional Visit Progress Note* is a critical MIHP form, as it is used to document what transpired at each visit. It includes fields for: whether or not visit was blended, trimester, beneficiary name and Medicaid number, type and location of visit, date of visit, time in and out, topics reviewed from the *MIHP Maternal and Infant Education Packet* or text4baby, whether or not beneficiary is a first time mother, whether or not RD physician order is in place, domain and risk level addressed, interventions provided (listed by number), mother/caregiver's reaction to interventions, other visit information, outcome of previous referrals, items tracked at every visit, including whether or not the beneficiary was asked if MIHP is meeting her needs (which must be asked at every visit), plan for next visit, new referrals made, signature of home visitor, and date of signature.

The *Professional Visit Progress Note* **must** indicate that one or more of the following activities were conducted at a given visit:

- 1) Plan of Care 2 risk domain interventions were addressed; or
  - 2) An issues identified by the beneficiary was addressed; or
  - 3) Issues identified through professional judgement of MIHP provider was addressed
- OR
- 4) If no risk was assessed, *include documentation related to the rationale for services*

The *Professional Visit Progress Note* was carefully designed to make documenting a visit as simple and quick possible. It consists of fill-in-the-blank fields, check-boxes and narrative sections. The narrative sections include:

- Mother/caregiver's reaction to interventions provided
- Other visit information
- Outcome of previous referrals
- Plan for next visit

Some MIHP professionals, who are used to writing extensive case notes, find it challenging to convert to the briefer format. See forms instructions and specific guidelines for completing the narrative sections of the *Professional Visit Progress Note* at the MIHP website.

#### Documenting Emergencies

There are several situations in which you are directed to document that the beneficiary had an emergency. For example, in order to see a beneficiary who is transferring into your MIHP but whose records you have not yet received, you must document that the beneficiary had an emergency. Emergencies are defined on the *Plan of Care 2* risk domains corresponding to the emergency risk-level interventions. In this transfer example, another factor that would qualify as an emergency is receipt of a CPS request to see the beneficiary immediately.

#### Documenting Multiple Visits in a Month

If it is necessary to see a beneficiary more frequently than once a month, document your rationale on the *Contact Log*. Seeing beneficiaries weekly or every two weeks may be necessary with some beneficiaries, but it should not be standard practice.

### **7. Plan of Care Implementation Monitoring**

The goal of implementation monitoring is to assure that the *POC 2* is being implemented appropriately and that the beneficiary's needs are being met. Monitoring spans the length of time the pregnant or infant beneficiary is in the program.

The case manager is responsible for making sure the individual beneficiary is receiving the best possible care by monitoring *POC* implementation thoroughly and systematically-on a quarterly basis, at a minimum. This is done by conducting chart reviews.

Chart review should occur at least quarterly in order to determine:

- a. Whether or not the beneficiary is being seen monthly. This means at least once in a given month. For example, if the beneficiary is seen on April 1 and then again on May 31, this requirement would be met.

If the beneficiary is not seen at least once in a given month, there must be documentation explaining the gap in service on the *Contact Log*. For instance, if you are spreading out 9 infant visits over the 12-month period of infancy, you would simply need to document that the beneficiary wasn't seen in a particular month because you are intentionally spreading out the allotted number of visits according to plan.

MIHP agencies can implement different procedures to ensure that beneficiaries are seen monthly. An agency may decide to have the case manager, MIHP program coordinator or

another office staff person look at each chart, use an Excel spreadsheet for tracking purposes, or come up with another way to track the date last seen.

The intent of requiring documentation that a beneficiary was or wasn't seen in a given month is to prevent long gaps in service during which the MIHP staff does not have contact with the beneficiary for several months and the agency does not have a systematic process for tracking the time between visits.

- b. The extent to which the POC is being implemented as developed and whether it needs modification.
- c. The extent to which the appropriate interventions are being implemented.
- d. Whether or not appropriate referrals have been made and followed up on.
- e. Whether or not the POC is meeting the beneficiary's needs.

As the case manager reviews the beneficiary's chart, he or she is looking for documentation that the team's activities are in keeping with the *POC 2*. The case manager identifies any task that has "fallen through the cracks", determines if barriers to achieving goals are being addressed, decides if the beneficiary should be discharged, and identifies the team's next steps.

You can choose the months in which you will conduct the quarterly chart reviews and the percentage of charts you will review. A suggestion for the percentage of charts to review is at least 10% of your open charts, but this is not a requirement.

You may document your quarterly reviews in whatever manner you choose. However, an optional *MIHP Care Coordinator Chart Review Form* is posted at the MIHP web site, should you wish to use it for documentation purposes.

The intent of chart review is to monitor and improve quality related to ensuring the beneficiary's needs are being met clinically and in the view of the beneficiary. It is recommended that case managers review their own charts, as well as participate in peer review of each other's charts. An important part of the chart review is to establish a protocol and practice of asking the beneficiary if MIHP is meeting her needs.

The following four forms are particularly helpful for monitoring *POC 2* implementation:

1. *Professional Visit Progress Notes*. See Section 4 above.
2. *Maternal Forms Checklist* or *Infant Forms Checklist* and *Maternal Transfers Checklist* or *Infant Transfers Checklist*. This is a one-page summary of the beneficiary's progression of care. It includes dates that various MIHP services are provided. It is required for QA purposes to assure that all MIHP are forms are included in the chart.
3. *Referral Log* (MDHHS form or own form). This is an optional form that is used to track referrals to various services and supports, dates that referrals are made, and dates that staff follow-up on referrals. Referrals must also be documented on the *Professional Visit Progress Note*.
4. The *MIHP Contact Log* (or an alternative contact log). A contact log is required in every MIHP chart. You may use the *MIHP Contact Log* or design your own form. The *MIHP Contact Log* is a very basic form. It provides spaces for the date, notes, and the initials of the professional or administrative staff person making an entry.

**Entries Required on Contact Log**

You are required to use the *Contact Log* to document:

1. Attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) if there's a gap in service between professional visits and from the last MIHP billable service to discharge. However, you are not required to log routine contacts, such as calling the beneficiary to confirm an upcoming appointment or to ask for directions to the beneficiary's home.

It is important that every attempt is documented so team members are aware of each other's efforts in this regard. It is also critical for risk management purposes, as this documentation may help to limit your legal liability in case the beneficiary is impacted based on what is identified in her chart (e.g., domestic violence, depression, child abuse, etc.) and your actions are questioned in an investigation or malpractice suit. Remember: *If it isn't documented, it didn't happen.*

2. Reason why the beneficiary has not been seen monthly (once in a given month) whenever there is a gap in service.
3. The specific purpose that an infant case is being kept open after four consecutive months of inactivity.
4. Refusal by the beneficiary or primary caregiver of any of the required elements of MIHP.

**Entries Required on Contact Log or in the in Professional Visit Progress Note**

You are required to use the *Contact Log* or *Professional Visit Progress Note* to document:

1. The reason why you added a risk domain or changed a risk level for a domain to the POC 2, based on the risk criteria listed in the POC 2.
2. Interventions provided at the *Risk Identifier* visit.
3. Reason why a particular POC 2 risk domain is not addressed.
4. A verbal order taken from a medical care provider over the phone.
5. A referral you make when talking with the beneficiary over the telephone.

**Entries Required on Contact Log, Prenatal or Infant Care Communication Form, or Written Message to Medical Care Provider**

You can document that you have notified the beneficiary's medical care provider that she has transferred into your MIHP in one of three ways:

1. Send the *Prenatal or Infant Care Communication Form*.
2. Send a letter or note.
3. Call the medical care provider's office and document the call on the *Contact Log*.

**Using the Contact Log for Other Purposes (Not Required)**

You are encouraged to use the log for other purposes as well. For example, you may use it to document:

1. Contacts with other service providers on behalf of the beneficiary.
2. Contacts among team members.
3. Decisions made among team members.
4. Any other information that would be useful for team members to have.

As you monitor the *POC 2*, keep the following considerations in mind:

- a. Make sure the appropriate interventions are being implemented, especially in the stress/depression, domestic violence, and substance-exposed infant domains, in which safety must be considered. Beneficiaries who score moderate or high on stress/depression must be referred to mental health services (may include infant mental health) or there must be documentation that the referral was discussed.
- b. Make sure all documents are accurate if there is a need to modify the *POC 2* at any time by adding a new domain based on professional judgment in light of new information obtained through interviews or observation.

Remember, if you add a new domain, complete the *Prenatal or Infant Care Communication form and the Beneficiary Status Notification Form* and forward it to the medical care provider. This is necessary because the addition of a domain to the *POC 2* constitutes a significant change in beneficiary status.

- c. In order to provide the most appropriate care, you should increase the risk level when the beneficiary's situation matches the risk information in the *POC 2*, so you can implement a higher level of interventions. You may change the risk level for a particular domain at any time, except prior to the first professional visit.

## **8. Coordination with Medicaid Health Plans (MHPs)**

- a. Communicate with Medicaid Health Plans (MHPs) as specified in *MIHP Provider – MHP Care Coordination Agreement (CCA)*, if you have one. The *CCA*, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available in the [Medicaid Provider Manual](#) in the *Forms Appendix*. The signed *CCA* agreement with a particular MHP may include provisions not included in the *Care Coordination Agreement* template, if both parties are in agreement.
- b. If you are out-of-network with a particular MHP and you are serving a pregnant woman or infant who becomes enrolled in that MHP, you are required to call the MHP to discuss operational details before providing out-of-network services.
- c. If you are out-of-network with a particular MHP and you encounter a pregnant woman or infant who is enrolled in that MHP, do not do administer a *Risk Identifier*. Call the MHP so they can assist the beneficiary to find an in-network MIHP.
- d. You must use the *Beneficiary Status Notification* form and the *Prenatal or Infant Care Communication* form to notify the MHP that one of their members has:
  - Enrolled in your MIHP
- e. You must use the *Beneficiary Status Notification* form to notify the MHP that one of their members has:
  - Transferred to your MIHP agency from another MIHP agency
  - Had emergency interventions implemented
    - Fax the form for this issue within 24 hours
  - Been discharged from your MIHP
    - You do not need to fax the discharge summary with the form.
    - This must be sent or faxed within 14 calendar days of entering the *Discharge Summary* into the MIHP database.
- f. Use the *MIHP-MHP Communication Tool* to communicate with the MHP about the status of maternal and infant referrals that they send to your agency or to identify MHP enrollees that you have otherwise encountered. This form, effective 8-1-17, is generated by the MHP or by the MIHP and may be faxed or mailed. The form and instructions for its use are available at the MIHP website.

- g. Contact the MHP contact person who is designated to work with MIHPs in order to coordinate transportation for mutual beneficiaries. If you are unable to resolve an issue with the MHP contact person, ask your consultant for assistance.
- h. If you have a contract with an MHP, there may be additional coordination and reporting requirements. These additional requirements may vary across MHPs.

## **9. Coordination with Medical Care Provider**

You are required to communicate with the medical care provider throughout the course of care for each beneficiary. There are two exceptions to this requirement. Do not send communications to the medical care provider if:

- a) The beneficiary or primary caregiver has not consented to release PHI to the beneficiaries medical care provider.
- b) The medical care provider is a clinic-based MIHP provider and there is documentation in the chart that the medical care provider does not wish to receive these communications.

In either of these instances, you are not required to communicate with the medical care provider nor are you required to complete, send, and file copies of the communication forms and *Beneficiary Status Notification*.

In all other instances, use the following forms to communicate with the medical care provider by fax or mail:

- 1) You must use the *Beneficiary Status Notification* form and the *Prenatal or Infant Care Communication* form to notify the medical care provider that their beneficiary has:
  - a) Enrolled in your MIHP
    - Indicate each risk for which there is a developed domain in the *POC 2*, including those identified by the *Risk Identifier* and those identified by professional judgment.
    - This form must be sent within 14 calendar days after the *Risk Identifier* visit is completed.
    - You are required to view the *Risk Identifier* score sheet online or print out it out prior to completing the *Prenatal or Infant Care Communication Form*.
    - You may send the *Communication Form* to the medical care provider before the *POC 3* is signed by both disciplines.
    - You should also call the medical care provider's office to notify the staff verbally that the beneficiary has enrolled in your MIHP and that documentation with the beneficiary's risk domains is forthcoming. Be sure to document this conversation on the *Contact Log*.
  - b) When there's a significant change in beneficiary status such as:
    - A new POC2 domain is added (however, not when the risk level is changed for a particular domain).\*
    - The beneficiary changes medical care providers. When a beneficiary informs you that she has a new medical care provider, ask her to update her *MIHP Consent to Release Protected Health Information* by adding the new medical care provider's name, initialing and dating it. After you have obtained authorization, send the new provider a copy of the initial *Prenatal or Infant Care Communication* form with a note explaining that it was originally sent to a previous medical care provider when the beneficiary first enrolled in MIHP.
    - Emergency interventions have been implemented. You must fax this form to the medical care provider within 24 hours.

- If you need to add a risk domain to the beneficiary's *POC 2* because it was omitted by the transferring agency, update the medical care provider noting that you are the beneficiary's new MIHP provider.
- 2) You must notify the medical care provider when a beneficiary is:
    - a) Transferred to your MIHP, however, you are not required to use the *Beneficiary Status Notification* form for this purpose. You may choose to use the form, write a note, or call the medical care provider. If you call, it must be documented in the chart on the *Contact Log*.
  - 3) You must use the *Beneficiary Status Notification* form and include the *Discharge Summary* to notify the medical care provider that their beneficiary has:
    - a) Been discharged from MIHP. The Discharge documents must be sent to the medical care provider within 14 calendar days from the date that the *Discharge Summary* data is entered into the MIHP database.

\*When there is a change in maternal risk while serving an infant beneficiary and you add a new domain to Maternal Considerations, you must update and sign the *POC3* but you are not required to send the update to the infant's medical care provider. However, if the newly-identified risk is one that may affect the infant's care (e.g., substance misuse, domestic violence, etc.), it is recommended that the medical care provider be alerted, if the mother has consented. Some MIHP providers have policies that expressly prohibit the sharing of maternal information with the infant's medical care provider.

#### **Other considerations for coordinating with the medical care provider:**

- a) Note that the *Prenatal and Infant Care Communication* forms and the *Discharge Summary* must be signed by an RN or SW.
- b) Forward a copy of the *Maternal Plan of Care or Infant Plan of Care* to the medical provider upon request.
- c) Do not release information to the beneficiary's medical care provider if you do not have a signed *Consent to Release PHI* to him or her. Be sure to document that communications were not sent for this reason.

## **10. Conclusion of MIHP Services**

Conclusion of MIHP services includes four steps:

- a. Conducting the final visit with the beneficiary (unless beneficiary is lost to service)
- b. Referring maternal beneficiary to the Healthy Michigan Plan, if applicable
- c. Completing the electronic *Maternal or Infant Discharge Summary*
- d. Notifying the medical care provider and MHP that the case has been closed

### **Conducting the Final Visit: Maternal**

The final maternal visit will be the postpartum visit, unless the beneficiary is lost to service before her 9<sup>th</sup> visit. If the beneficiary has not been lost to service, the final visit will most likely focus on completing one or more interventions, celebrating the beneficiary's successes while in MIHP, encouraging her to enroll in other services and supports if indicated, getting her feedback on MIHP, transitioning the family to the infant portion of the program or, if services are no longer desired, ending the beneficiary-worker relationship.

During this final visit you should solicit feedback on how the beneficiary experienced MIHP. Two simple questions may assist.

1. What did you like best about MIHP?
2. How could MIHP have been better for you?

Explain to her that what she says is important because you will use her feedback to improve MIHP for other pregnant women and new mothers. This will assist you as a MIHP provider to improve the quality of your program. You may document her feedback on the *Discharge Summary* in the comments section.

### **Refer Maternal Beneficiary to the Healthy Michigan Plan when Healthy Kids for Pregnant Women Medicaid Ends**

When a mother's Healthy Kids for Pregnant Women Medicaid coverage is ending and she will not have other health care insurance, help her find out if she is eligible for the Healthy Michigan Plan (Medicaid expansion under the Affordable Care Act). The Healthy Michigan Plan is another Medicaid program. It covers adults with income at or below 133% of the federal poverty level. (NOTE: Healthy Kids for Pregnant Women Medicaid covers women at or below 185% of the federal poverty level, so not all MIHP beneficiaries will qualify for the Healthy Michigan Plan.)

Individuals are eligible for this program if they:

- Are 19-64 years
- Have income at or below 133% of the federal poverty level (\$16,000 for a single person or \$33,000 for a family of four).
- Do not qualify or are not enrolled in Medicare
- Do not qualify or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

An application can be filed at any time in one of the following ways:

- Online at
- Over the phone at 1 855-789-5610
- In-person at a local MDHHS office

Applicants will need to have the following information:

- Birthdates and Social Security Numbers of everyone included on the application, including dependents
- Employer and income information for everyone in the family, such as a W-2 form or wage statement
- Policy numbers for current insurance plan, if there is one
- Information on any job-related insurance that's available to the family
- Citizenship and immigration status

The following publications describing the program are available at [MDHHS - Healthy Michigan Plan Provider Information](#)

1. *Healthy Michigan Plan Brochure*  
This is a tri-fold brochure with basic information.
2. *Healthy Michigan Plan Handbook*  
This is a 16-page handbook with more information about the program.
3. *Healthy Michigan Plan Flyer*

Email [healthymichiganplan@michigan.gov](mailto:healthymichiganplan@michigan.gov) to request copies of the brochure or handbook.

Additional resources for providers: [www.michigan.gov/healthymichiganplan](http://www.michigan.gov/healthymichiganplan)

Additional resources for families: [www.healthymichiganplan.org](http://www.healthymichiganplan.org)

If a beneficiary does not qualify for the Healthy Michigan Plan, she may qualify to purchase subsidized health insurance coverage through the federal Health Insurance Marketplace (health insurance exchange).

In addition to assisting the beneficiary to obtain health insurance before she leaves MIHP, be sure to give her information on Title X family planning clinics in her area. A list is available at [MDHHS Title X Family Planning Clinic Directory](#).

### **Conducting the Final Visit: Infant**

If other supports and services are indicated, bring the relevant brochures and contact information with you to the final visit. If primary caregiver still appears to be dealing with depression, alcohol or substance misuse, domestic violence, or a chronic disease and has not sought treatment, make another attempt to help her to do so.

### **Encourage Enrollment in another Family Support Program**

Encourage families, especially those who are at high risk at discharge, to enroll in another home visiting program so they will have continuing support. If no other home visiting program is available, suggest learn and play groups, parenting classes, family resource centers and any other family support programs that are offered locally. Your Great Start Collaborative (GSC) Coordinator should be able to provide you with this information. The GSC may publish a *Parent Resource Guide* or have one posted online and you could hand every beneficiary a list of local resources for families with young children at the final visit, encouraging her to keep it for future reference as her infant gets older.

### **Encourage Enrollment in Imagination Library**

If you have an Imagination Library in your area, help the beneficiary sign up for it. Imagination Library provides a free, age-appropriate book every month to enrolled children from birth to age five. Books are mailed directly to the child's home. There is no income eligibility requirement and the program is free, regardless of ability to pay. There are Imagination Libraries serving many Michigan counties and cities, although some limit eligibility to children whose parents are participating in a particular parenting program. To find out if there is one in your area and if there are any eligibility restrictions, ask your GSC Coordinator or go to [http://usa.imaginationlibrary.com/find\\_my\\_affiliate.php](http://usa.imaginationlibrary.com/find_my_affiliate.php).

### **Discuss How to Access Child Development Resources**

Explain to the primary caregiver that although you will not be there to conduct any more ASQ-3 and ASQ: SE-2 screenings, there are ways that she can continue to learn about her child's ongoing development. She can do this by talking to her pediatrician, participating in a family support program, or looking at one or more of the following websites:

#### *General Child Development*

- Bright Futures Parent Handouts (American Academy of Pediatrics)  
<https://brightfutures.aap.org/families/Pages/Resources-for-Families.aspx>  
(English and Spanish)  
Handouts with information about children at 12-months, 15-months, 18-months, 2-years, 2½ years, 3 years and 4 years.
- PBSparents at <http://www.pbs.org/parents/child-development/>
- CDC Parent Information <http://www.cdc.gov/parents/index.html>
- CDC Child Development at <http://www.cdc.gov/ncbddd/childdevelopment/index.html>

*Social and Emotional Development*

- ZERO TO THREE at <http://zerotothree.org/child-development>
- Center on the Social and Emotional Foundations for Early Learning – Resources: Family Tools at <http://csefel.vanderbilt.edu/resources/family.html>

Your GSC may be able to provide you with some parenting materials that you could give to your beneficiaries at the final visit.

**Completing the *Discharge Summary***

The *Maternal Discharge Summary* and the *Infant Discharge Summary* are comprehensive electronic forms that capture demographic data, risk levels, interventions provided, progress during maternal or infant interventions, and referrals made. Some beneficiary outcomes are captured under “progress during maternal or infant interventions.” It is recommended that you have the chart in front of you as you complete the electronic *Discharge Summary*.

The individual who completes the *Discharge Summary* must be a RN or SW but need not be the case manager. The *Discharge Summary* also can be completed by the MIHP program coordinator, if the coordinator is an RN or SW.

***Discharge Summary Required for Every Beneficiary Enrolled in MIHP***

If you enroll a beneficiary in MIHP, you must complete a *Discharge Summary*. This is true even if the beneficiary declines MIHP services or is lost to service after the *Risk Identifier* visit. If you implement interventions during the *Risk Identifier* visit and that is your only contact with the beneficiary, document the interventions on the *POC 2* and the *Discharge Summary*.

***Discharge Summaries for Family Served with Blended Visits***

At times, you will have *Risk Identifiers* and open cases on more than one family member at the same time, serving them with blended visits. You will need to do a separate *Discharge Summary* for each family member.

When you discharge multiples, you must complete a separate *Discharge Summary* for each infant. However, only the *Discharge Summary* for the infant whose Medicaid ID number is being used for billing purposes is completed in its entirety, and only the interventions provided for the infant being billed are reflected on this *Discharge Summary*. For the other infants, an abbreviated *Discharge Summary* is done, indicating that they had an *Infant Risk Identifier*, but no visits. A chart reviewer would need to look at “other visit information” on the *Professional Visit Progress Notes* in the first infant’s chart to see what interventions were provided for the other infants. See *Discharge Summary Instructions* at the MIHP website for detail on completing *Discharge Summaries* for multiples.

***Discharge Summary for Infant in Foster Care***

If the infant is in foster care at the time of discharge, indicate the intervention numbers that were addressed with both the mother and the foster family on the *Discharge Summary*. Note in the comments section of the *Discharge Summary* that you have been working with the foster parent and do not know mother’s status at discharge.

**Date of Discharge**

The *Discharge Summary* must be entered into the MDHHS database within 30 calendar days after:

- a. The pregnant woman's MIHP eligibility period ends
- b. Infant services are concluded (e.g., infant ages out of program; all available visits have been used; services are no longer required; parent or caregiver requests discontinuation of services; the family moves, etc.) or there are four consecutive months of inactivity, unless there is documentation on the *Contact Log* that the case is being kept open for a specific purpose and the purpose is stated.

The discharge date is the date that the completed *Discharge Summary* is entered into the MIHP database. This must be done within 30 calendar days of your determination that services have ended, eligibility has ended, or the family has been lost to follow-up.

If a *Discharge Summary* is not entered within 30 calendar days after the pregnant woman's MIHP eligibility ends or infant services are concluded, there must be a documented explanation in the chart. For example, "Migrant worker family is planning to return to the area within the service delivery period."

**Notifying the Medical Care Provider and MHP that the Case Has Been Closed**

The *Beneficiary Status Notification* and the *Discharge Summary* must be mailed or faxed to the medical care provider within 14 calendar days from the date that the *Discharge Summary* data is entered into the MIHP database.

The *Beneficiary Status Notification* must be mailed or faxed to the MHP within 14 calendar days from the date that the *Discharge Summary* data is entered into the MIHP database. You are not required to attach the *Discharge Summary*.

**MIHP Program Additional Requirements****Family Planning**

*Michigan's Infant Mortality Reduction Plan (2016-2019)* includes the following goal:

Goal 8d: To promote reproductive planning for all childbearing-age adults as a component of primary care and promote access to reproductive health services.

MDHHS places a high priority on assisting women to avoid unintended pregnancies and to space pregnancies at least 18 months apart, given that short birth intervals are associated with adverse outcomes. This means that family planning interventions are crucial in MIHP.

Medicaid MIHP policy states that: *Family planning options should be discussed throughout the course of care, giving the woman time to consider her options. (Section 2.7 Professional Visits, MIHP, Medicaid Provider Manual).*

MIHP providers are required to:

1. Discuss family planning at every maternal visit with referrals to family planning services as needed. The literature shows that discussing family planning with a woman during the first trimester and throughout her pregnancy is more effective than waiting until after she delivers.  
(Guidelines for Prenatal Care, Sixth Edition 2007. American Academy of Pediatrics, American College of Obstetricians and Gynecologists).

2. Assist the maternal beneficiary to make and keep her postpartum medical care provider appointment, at which time family planning will be addressed (e.g., help her make the appointment, arrange transportation if necessary, help her prepare questions for her medical care provider, etc.).
3. Discuss family planning at every infant visit with the mother (or father, if he is the primary caregiver), with referrals to family planning services as needed. Family planning need not be discussed if:
  - a. The mother has undergone operative or non-operative permanent sterilization.
  - b. The mother or father (if he is the primary caregiver) refuses to discuss family planning.

All staff should be familiar with the [MDHHS Family Planning Website](#) and *Discussing Family Planning*, on the MIHP website.

Referrals to family planning must be made, if indicated. Family planning resources, which may be shared with beneficiaries, are available at the MIHP website.

#### Family Planning Services when Beneficiary Loses Healthy Kids for Pregnant Women Medicaid

Many MIHP beneficiaries lose their Medicaid coverage at the end of two calendar months following the month the pregnancy ends. At that point, they have no way to pay for family planning services.

A beneficiary who is losing her Healthy Kids for Pregnant Women Medicaid coverage should be encouraged to apply for the Healthy Michigan Plan (Medicaid expansion under the Affordable Care Act). See section titled *Refer Maternal Beneficiary to the Healthy Michigan Plan when Healthy Kids for Pregnant Women Medicaid Ends* earlier in this chapter.

Also make sure that the beneficiary is aware that family planning services are offered at Title X family planning clinics. A list of family planning clinics is posted on the MIHP website.

MOMS participants are eligible for family planning services during the 60-day postpartum period (MSA 16-47).

### **Infant Safe Sleep**

*Michigan's Infant Mortality Reduction Plan (2016-2019)* includes the following goal:

Goal 5. Reduce sleep related deaths and disparities.

MIHP providers are required to:

- a. View the online training titled *Infant Safe Sleep for Health Care Providers* on the MIHP website.
- b. Discuss infant safe sleep with the beneficiary or caregiver at least once and document this on the *Professional Visit Progress Note*.

All staff should be familiar with the [MDHHS Safe Sleep Website](#) and [The American Academy of Pediatrics guidelines](#) for Safe Infant Sleeping Environment.

Every two to three days in Michigan, an infant dies due to being placed to sleep in an unsafe environment. Sleep-related infant deaths are the third leading cause of all infant death in Michigan and the leading cause of death among infants 1 month to 12 months old. They are considered the most preventable type of infant death. It is critical that MIHP beneficiaries are educated on infant sleep safety and are supported in providing a safe sleep environment for their infant throughout their participation in MIHP.

Infant sleep safety should be discussed at every MIHP visit, using a conversation style that is non-judgmental, non-confrontational and strength-based. Having an appropriate sleep environment prepared for the infant prior to arrival home from the hospital is essential. The majority of infant deaths due to unsafe sleep occur while the baby is under 4 months old, so safe sleep must begin the first day home from the hospital. All staff should be familiar with the most recent American Academy of Pediatrics guidelines for infant sleep safety and providers should review these with the beneficiary, family members, and anyone else who is providing care for the infant.

MDHHS Safe Sleep also has free brochures, videos and other resources available on their website. Free brochures, posters, decals and DVDS can also be ordered at: <http://www.healthymichigan.com>

For questions or for additional information, please contact the Michigan Department of Health and Human Services Safe Sleep Coordinator at (517) 335-1954.

## Prevention of Early Elective Delivery

*Michigan's Infant Mortality Reduction Plan (2016-2019)* includes the following goal:

Goal 3. Reduce premature births and low birth weight. Promote the adoption of policies to eliminate unnecessary deliveries before 39 weeks gestation to minimize complications of the mother and baby due to medically unnecessary deliveries.

MIHP providers are required to:

- a. View the online training titled *Prevention of Early Elective Delivery* at the MIHP website.
- b. Discuss the prevention of early elective delivery with the pregnant beneficiary at least once during pregnancy, and document this on the *Professional Visit Progress Note*.

## Immunizations

*Michigan's Infant Mortality Reduction Plan (2016-2019)* includes the following goals:

Goal 7d: Promote immunizations for adolescents and pregnant women.

Goal 4d: Promote family centered medical homes and well-child visits including immunizations.

Medicaid MIHP policy states that: *Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary's (i.e., mother and/or child) immunizations. The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. (Section 2.14 Immunizations, MIHP, Medicaid Provider Manual).*

MIHP providers are required to:

1. Discuss the mother's immunization status at least once during pregnancy.
2. Discuss the infant immunization at least once during pregnancy.
3. Discuss the infant's immunization status at every infant visit.
4. Assist the maternal beneficiary and the primary caregiver of the infant beneficiary to obtain immunizations (e.g., help make the appointment, arrange transportation if necessary, help prepare questions for the medical care provider, etc.).
5. Review the beneficiary's immunization information frequently and include a copy if the *MCIR Immunization Record* into the chart as follows:  
 Maternal beneficiaries: At least once during the course of care.  
 Infant beneficiaries: At least 4 months, 6 months, and 12 months of age.

If there is no record of a beneficiary in the MCIR system, document this by including a copy or screenshot indicating there is no MCIR record for the beneficiary.

To see the child immunization schedule recommended by the Centers for Disease Control and Prevention, US Department of Health and Human Services, go to [www.michigan.gov/mihp](http://www.michigan.gov/mihp) and click on “Families,” then “Education & Information for Parents,” then “Infant Health and Safety,” and then “Immunization Schedule for Babies and Young Children.”

To see information on maternal vaccines before, during and after pregnancy, go to [Pregnancy and Vaccination](#) | [Vaccines for Pregnant Women](#) | [CDC](#).

## Michigan Care Improvement Registry

The Michigan Care Improvement Registry (MCIR) was created in 1998 in order to collect reliable immunization information for children throughout the State of Michigan. It has been successful in reducing both vaccine-preventable diseases and over-vaccination. All immunizations administered to every child born after December 31, 1993 and less than 20 years of age must be reported in MCIR within 72 hours of administration. In 2006, MCIR transitioned from a child immunization registry to a lifespan registry and now includes adult immunizations as well.

MIHP providers have read-only access to the MCIR database. Providers are required to access this database in order to review individual beneficiary records and follow up with beneficiaries as needed.

The *MIHP Personnel Roster* includes a column to designate the staff members authorized by the agency to access MCIR through MILogin. Instructions to register as a MCIR user are at the web site. If you have questions, contact Maria Garcia at 517 241-9366 or [garciam14@michigan.gov](mailto:garciam14@michigan.gov). More information about MCIR is available at <https://www.mcir.org/>.

## Linking to *Early On* and the Great Start Collaborative

Each MIHP is required to be linked to, or serve as a member of, the Part C/*Early On* Interagency Coordinating Council and the Great Start Collaborative Council (GSC) in each of the counties it serves. If the MIHP serves five counties, it needs to be linked to *Early On* and the GSC in all five counties.

### ***Early On***

The MIHP needs to have a working relationship with *Early On* through which referrals may be facilitated (both ways) and care is coordinated for mutual clients. This relationship is critical because MIHP screens infant beneficiaries for potential developmental delays resulting in a significant number of referrals to *Early On*.

When an MIHP infant is involved with another program such as *Early On* or Children’s Protective Services, the MIHP provider is encouraged to participate in care coordination meetings facilitated by the other program (not a separately reimbursable activity under MIHP) in order to reduce duplication of services and better serve the family.

### **Great Start Collaborative**

The MIHP needs to be linked to the local or regional Great Start Collaborative (GSC) because the GSC is responsible for building a coordinated system of community resources and supports to ensure that every Michigan child from birth to 8 is:

1. Born healthy
2. Healthy, thriving and developmentally on track from birth through third grade
3. Developmentally ready to succeed in school at time of school entry

4. Prepared to succeed in fourth grade and beyond by reading proficiently by the end of third grade

GSCs focus on promoting: pediatric and family health; social and emotional health; family support; parenting leadership; and child care and early learning. The MIHP should know about this coordinated system of resources and supports since one of MIHP's key functions is to refer pregnant women and infants to needed services. It is also important that the MIHP is visible to and has a relationship with the GSC, so the GSC can promote your services to parents and other early childhood providers in the community. At a minimum, you must receive regular communications from the GSC in each county served by your MIHP.

### **Childbirth Education Group Classes**

MIHP providers are required to encourage every first-time mother to complete a childbirth education (CBE) course. Referrals of first-time mothers to CBE must be documented in the beneficiary's record. However, in some communities, there are few or no affordable CBE options for MIHP beneficiaries. If your MIHP serves an area where there are no CBE resources, contact your MIHP consultant to determine the best way to provide CBE for your beneficiaries.

The MIHP provider may choose to teach and bill Medicaid for childbirth education (CBE) classes. CBE can be billed one time per beneficiary per pregnancy. The pregnant woman must attend at least ½ of the classes or cover at least ½ of curriculum described in the course outline before Medicaid is billed. There are no requirements as to how many classes must be provided or how long each class must be. However, there are content requirements.

Required content for MIHP-reimbursable childbirth education classes is indicated by the major headings listed below, while bullets indicate suggested content:

#### **Pregnancy**

- Health care during pregnancy
- Physical and emotional changes during pregnancy
- Nutrition

#### **Labor and Delivery**

- Signs and symptoms of labor, including information regarding pre-term labor
- Breathing and relaxation exercises
- Analgesia and anesthesia
- Avoiding complications
- Coping skills
- Types of deliveries
- Episiotomy
- Support techniques
- Hospital tour

**Infant Care**

- Preparation for breastfeeding
- Infant feeding
- Newborn immunizations
- Infant car seat use
- Newborn attachment

**Postpartum Care**

- Postpartum physical and emotional changes, including depression
- Feelings of partner
- Potential stress within the family
- Sexual needs
- Exercise

**Importance of Family Planning**

- Methods of contraception
- Spacing pregnancies
- Family planning resources

If one MIHP provider chooses to offer CBE classes, it is acceptable for beneficiaries from other MIHPs to participate in the classes. The MIHP providing the classes is responsible for billing for reimbursement for the beneficiaries in attendance, including those from other MIHPs.

If a beneficiary is homebound because of a medical condition or some other unusual circumstance, CBE may be provided in her home as a separately billable service. There must be written documentation from the medical provider in the chart stating why one-on-one CBE was needed and where it took place. There must also be documentation that at least ½ of the curriculum was covered. Alternatively, the MIHP provider may provide one-on-one CBE under the *POC 2 - Pregnancy Health* domain and bill it as a regular professional visit.

**Childbirth Education Resources**

MIHP providers are expected to know about the CBE programs in their service area. This information may be available from the Great Start Collaborative or from 2-1-1. In some service areas, face-to-face CBE classes are unavailable. Even if they are available, some beneficiaries may choose not to enroll in them. In these situations, online CBE may be helpful.

The March of Dimes has excellent current and visually appealing CBE resources geared to low-level readers. For example, they have developed a free iPad app titled “My 9 Months” that birth professionals can use to educate expecting moms and their families. They also have brief videos of a small diverse group of pregnant women learning about signs of labor, signs of premature labor, and stages of labor available at [Childbirth education classes / March of Dimes](#), along with other resources. BabyCenter also has a free online childbirth class consisting of 51 short videos at [Childbirth class: Free video series | BabyCenter](#).

**Parenting Education Group Classes**

The MIHP provider may choose to teach and bill Medicaid for parenting education classes, but only if no other community-based organization is providing no-cost parenting classes in the area. MIHP parenting education classes can be billed one time per infant or per family in the case of multiple infants. The

parent must attend at least ½ of the classes or cover at least ½ of the curriculum described in the course outline before Medicaid is billed. There are no requirements as to how many classes must be provided or how long each class must be. However, there are content requirements.

Required content for MIHP-reimbursable parenting education classes is indicated by the major headings listed below, while bullets indicate suggested content:

### **Feeding Recommendations throughout the First Year of Life**

- Nutritional requirements
- Developmental issues related to feeding children
- Breastfeeding advantages
- Formula preparation and breastfeeding

### **Normal and Abnormal Patterns of Elimination**

- Normal range of elimination patterns and changes throughout childhood
- Toilet training issues and developmental readiness

### **Common Signs and Symptoms of Infant Illness**

- Appropriate care for common illnesses
- Danger signs and when to call the health care provider
- Emergency numbers (i.e., poison control, emergency room, etc.)

### **Common Childhood Injuries and How to Care for Them**

- Signs and symptoms – when to seek medical care
- Basic first aid
- Accident prevention and safety

### **Normal Range of Sleep, Rest, Activity and Crying Patterns**

- How to assist an infant in settling to sleep
- Normal patterns of sleep and activity and developmental changes
- Information on safe sleep environment
- Signs and symptoms of over-stimulation and under-stimulation
- How to quiet a crying baby
- How to play with a baby to encourage optimum development

### **Hygiene**

- Hygiene needs of infants
- Appropriate care of routine problems (e.g., diaper rash, seborrhea, circumcision, etc.)

### **Normal Developmental Milestones of Infants Throughout the First Year**

- Developmental issues relating to providing care, feeding, and stimulation
- Realistic expectations of infants in relationship to their developmental level

### **Emotional Needs**

- Parent-infant interactions and attachment
- Normal changes that occur throughout the first year of life and their impact on infant-parent interaction
- Discussion and modeling of parenting behaviors that positively impact the emotional well-being of the infant

### **Protection from Toxic/Hazardous Wastes**

- Paint
- Lead
- Water

### Immunizations and Health Maintenance

- Well-baby visits
- American Academy of Pediatrics recommended schedule
- Care of the infant after immunization

### Day-to-day Living with Infants and Young Children

- Appropriate methods for managing activities and stress when living with infants and children
- Secondhand smoking
- Appropriate ways of handling infant behavior

## Developmental Screening

### Introduction to the *Ages and Stages Questionnaires-3 (ASQ-3)* and the *Ages & Stages Questionnaires: Social/Emotional-2 (ASQ: SE-2)*

Infancy is a dynamic time of change across multiple developmental domains. An infant's status may change in a surprisingly short period of time. Unless ongoing developmental screening is conducted, early identification of potential concerns may not occur, and the necessary referral, support and treatment may not be provided for the infant. Therefore, developmental screening must be provided for all MIHP infant beneficiaries.

#### ASQ Developmental Domains

The ASQ-3 is used to monitor and identify issues in general infant development in the communication, gross motor, fine motor, problem-solving, and personal-social domains. The ASQ: SE-2 is used to monitor and identify issues in infant development in the social-emotional domain.

The ASQ: SE-2 focuses deeply and exclusively on children's social and emotional behavior, including self-regulation, compliance, adaptive functioning, autonomy, affect, social-communication, and interaction with people. Children who are exposed to risk factors such as poverty or toxic stress are more likely to experience depression, anxiety, and anti-social behavior. With the typical ups and downs of young children's emotions and behavior, delays or problems can be easily missed. The ASQ: SE-2 is intended to help home visiting programs, early intervention programs, Early Head Start, Head Start, child welfare agencies, and other early childhood programs accurately screen infants and young children to determine who would benefit from an in-depth evaluation in the area of social-emotional development.

#### ASQ Questionnaires Were Developed to be Completed by Parents

ASQ questionnaires were developed to be **completed by parents** and scored by professionals, paraprofessionals or clerical staff. The parent tries activities with the child and/or answers quick questions about the child's abilities. It takes about 15 minutes for a parent to complete the questionnaire. Having parents complete the ASQ is not only cost effective, but also *enhances the accuracy* of screening - regardless of socioeconomic status, location, or well-being - by tapping into parents' in-depth knowledge about their children.

You can mail or give the ASQ to a parent and ask her to complete it before your next visit. Or, you can help a parent complete the ASQ during a visit if she is unable to read or has other difficulties completing it independently. (There is also an online completion option, but programs must purchase a subscription to this service.)

MIHP uses the ASQ screening tools to determine if a child should be referred to *Early On* for a comprehensive developmental evaluation. The tools are also useful in helping parents learn about how to promote infant development.

### **Why MIHP Uses the ASQ-3 and ASQ: SE-2**

The decision to require all MIHP providers to use the same screening tools is based on three reasons:

1. The ASQ-3 and ASQ: SE-2 are reliable, cost-effective, culturally-sensitive, and easy for parents to use (written at 4th - 5th grade reading level).
2. Using the same screening tools for all infants is important for MIHP evaluation purposes in the future.
3. By using these tools, we are helping to build a statewide developmental monitoring system, as an increasing number of early childhood programs and providers are utilizing the ASQ-3 and ASQ: SE-2 as their screening tools of choice.

### **ASQ Training**

The MIHP program coordinator should make sure that professional staff are very familiar with this section of the *MIHP Operations Guide* and that they are well-trained on using the ASQ tools. Staff who conduct ASQ screenings must view the no-cost online training titled *ASQ-3 and ASQ: SE-2 Developmental Screening in MIHP* at the MIHP website. The training explains how to administer and score the ASQ-3 and ASQ: SE-2. Staff must also become very familiar with the *ASQ-3 User's Guide*, the *ASQ-3 Learning Activities* book and the *ASQ: SE-2 User's Guide*.

#### ASQ Training Videos Produced by Brookes Publishing

Three training DVDs are available from Brookes Publishing at a cost of @ \$50 each (2016). These DVDs are titled:

1. *The Ages and Stages Questionnaires on a Home Visit*
2. *ASQ-3 Scoring and Referral*
3. *ASQ: SE-2 in Practice* (26 minutes)

Brookes also has archived three webinars addressing changes in the *Ages and Stages Questionnaires* and discussing ways to best utilize both the ASQ: SE-2 and the ASQ-3. The links are available on YouTube. Links are also available on the Brookes Publishing website at <http://agesandstages.com/>

#### **1. What's New for ASQ: SE-2**

Taped by developers Jane Squires and Diane Bricker

<https://www.youtube.com/watch?v=L8t9DAPKgLA>

The ASQ: SE-2 is different from the previous edition in the following ways:

- A two-month questionnaire has been added that screens infants 1 month 0 days to 2 months, 30 days.
- New items have been added that evaluate early communication, regulatory and autism spectrum disorders.
- New design and format, which is easier to read and use.
- Now age adjusts at 37 weeks gestation from birth until infant reaches age 2.
- Ages have been extended to cover the entire preschool age range (1-72 months).

#### **2. Using the ASQ-3 and the ASQ: SE-2 Together**

Taped by developer Jane Squires and team members

<https://www.youtube.com/watch?v=0NC14OoDesg>

### 3. Promoting Family Engagement with the ASQ: SE-2

Taped by Elizabeth Twombly and Kimberly Murphy

<https://www.youtube.com/watch?v=ccZ0bw8QQro>

#### **ASQ Questionnaire Intervals: Selecting the Right Questionnaire Based on Age**

It's important to distinguish between ASQ questionnaire intervals and ASQ administration intervals. ASQ questionnaire intervals pertain to selecting the correct questionnaire based on the child's age; ASQ administration intervals are the points in time that a particular program decides to administer the ASQ.

Questionnaire intervals are the different versions of the questionnaire based on the child's age in months. The ASQ-3 has 21 questionnaire intervals (2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months). The ASQ: SE-2 has nine questionnaire intervals (2, 6, 12, 18, 24, 30, 36, 48, and 60 months). Each questionnaire interval covers a range of months.

If an infant is not the exact age of one of the questionnaire intervals listed above, use the **ASQ Calculator** at [www.agesandstages.com/free-resources/asq-calculator](http://www.agesandstages.com/free-resources/asq-calculator) to determine which questionnaire interval to use. For example, the calculator indicates that if an infant is 3 months 0 days through 4 months 30 days, use the 4 month questionnaire.

When selecting the ASQ-3 or ASQ: SE-2 questionnaire to match the child's age, the age must be adjusted if the child is younger than 24 months at the time of screening and was born 3 or more weeks prematurely. The ASQ Calculator quickly and easily adjusts for prematurity in order to select the right tool. Use of the ASQ Calculator is recommended, as it reduces the odds of calculation errors.

The ASQ authors have determined that infant must be at least one month old before it's appropriate to administer the ASQ-3. Likewise, the infant must be at least one month old before it's appropriate to administer the ASQ: SE-2.

The timing of MIHP developmental screenings using the ASQ-3 and ASQ: SE-2 is discussed below.

#### **ASQ Administration Intervals: When MIHP Administers the ASQ-3 and ASQ: SE-2**

Administration intervals are the points at which the ASQ-3 and ASQ: SE-2 are repeatedly administered in MIHP. MDHHS requires that MIHP providers administer the ASQ-3 every 4 months if development appears to be on schedule. However, if the ASQ-3 score is close to the cutoff, screening must be repeated in 2 months.

MDHHS requires that MIHP providers administer the ASQ: SE-2 at the following points in time: before the infant reaches 3 months; before the infant reaches 9 months; before the infant reaches 15 months, and before the infant reaches 21 months, if development appears to be on schedule. However, if the ASQ: SE-2 score is close to the cutoff, screening must be repeated in 2 months.

### Using ASQ Scores to Determine What Action the MIHP Provider Should Take

The infant's total ASQ-3 score will fall under one of three categories. The categories are listed in the table below with the specific action that the MIHP provider should take with respect to each category.

Total ASQ-3 Score Category	Take This Action
Score is <b>below</b> the cutoff; further assessment with a professional may be needed.	Discuss with family, refer the infant to <i>Early On</i> for a comprehensive developmental evaluation, document in record.
Score is close to the cutoff.	Repeat the screening in <b>two</b> months. Provide learning activities and monitor.
Score is above the cutoff; development appears to be on schedule.	Repeat the screening in <b>four</b> months.

The infant's total ASQ: SE-2 score will fall under one of three categories. The categories are listed in the table below with the specific action that the MIHP provider should take with respect to each category.

Total ASQ: SE-2 Score Category	Take This Action
Score is <b>above</b> the cutoff; further assessment with a professional may be needed.	Discuss with family, refer the infant to <i>Early On</i> for a comprehensive developmental evaluation, document in record. Alternatively, refer to Infant Mental Health.
Score is close to the cutoff.	Repeat the screening in <b>two</b> months. Provide learning activities and monitor.
Score is below the cutoff; development appears to be on schedule.	Repeat the screening at the next MIHP - required age interval.

Although you only are required to provide learning activities when an infant scores close to the cutoff (gray zone) in a particular domain, it is strongly suggested that you provide learning activities to each family during or after each ASQ-3 and ASQ: SE-2 screening.

Remember that you may refer an infant to *Early On* for a comprehensive developmental evaluation, based solely on your professional opinion, when the infant is too young for the ASQ-3 or ASQ: SE-2 to be administered, or when you or the parent suspect there is a developmental concern that is not reflected in the infant's ASQ scores. If the developmental concern is in the social-emotional domain, you may refer to infant mental health services instead of *Early On*.

If the family declines an *Early On* or infant mental health services referral, document this in the chart. At a minimum, simply state: The family declined to accept an *Early On* or infant mental health services referral. If the infant is referred to *Early On*, but does not qualify for *Early On* or infant mental health services, document this in the chart. In either of these situations, share the ASQ-3 and ASQ: SE-2 learning activities with the family.

The total number of ASQ-3s and ASQ: SE-2s administered over the course of MIHP service will vary from infant to infant, depending on a variety of factors, including the following:

1. The age of the infant at MIHP entry
2. How long the infant is in MIHP
3. The infant's ASQ score at each administration
4. Whether or not ASQs are being administered by another program serving the infant
5. Whether or not the infant is referred to *Early On* for a comprehensive developmental evaluation

### MIHP Developmental Screening Begins with the *Infant Risk Identifier*

MIHP developmental screening actually begins at program enrollment, when the *Infant Risk Identifier* is administered. The *Infant Risk Identifier* includes developmental screening questions from *Bright Futures*, an initiative of the American Academy of Pediatrics. *Bright Futures* screening questions are included for each of the following age ranges:

- Less than 3 weeks
- 3 to 4 weeks
- 1 month 0 days to 2 months 30 days
- 3 months 0 days to 4 months 30 days
- 5 months 0 days to 7 months 30 days
- 8 months 0 days to 10 months 30 days
- 11 months 0 days to 12 months 30 days
- 13 months 0 days to 15 months 30 days

There are 5 to 11 screening questions for each *Bright Futures* age range. The individual who is administering the *Infant Risk Identifier* selects the age-appropriate set of questions, adjusting for prematurity, as needed. See “Adjusting for Prematurity across MIHP Developmental Screening Tools” later in this chapter.

Once the *Infant Risk Identifier* has been administered and *Bright Futures* screening has been repeated, if necessary, all follow-up developmental screening is conducted using the ASQ tools. There is one exception, however; the ASQ-3 is not administered with an infant who is younger than one month of age, per the publisher’s instructions.

The timing of the initial follow-up screening using the ASQ tools depends on the primary caregiver’s responses to the *Bright Futures* questions, as detailed below:

#### Positive *Bright Futures* Screen (concern is triggered):

1. If the infant is less than two months old and at least one *Bright Futures* “not yet” box is checked, administer the ASQ-3 within two weeks. (The infant must be at least one month old before it’s appropriate to administer the ASQ-3. If the infant is less than one month old, use the age-appropriate *Bright Futures* questions from the *Infant Risk Identifier*.)
2. If the infant is two months or older and at least two *Bright Futures* “not yet” boxes are checked, administer the ASQ-3 within two weeks. If the infant is at least three months old, also use the ASQ: SE-2. (The infant must be at least one month old before it’s appropriate to administer the ASQ: SE-2.) You are not required to administer both the ASQ-3 and the ASQ: SE-2 at the same visit.

There is a document at the MIHP website titled *Bright Futures Re-screening Questions - Infants Less than One Month of Age*. If re-screening is indicated, use this document to capture the results of the follow-up screening and file it in the infant’s chart.

### When to Administer the Initial ASQ-3 and ASQ: SE-2

If no concerns are triggered by the *Bright Futures* screen in the *Infant Risk Identifier*, administer the initial ASQ-3 **at the first professional visit (not the *Risk Identifier* visit) unless the infant is not yet two months old. In this case, administer the ASQ-3 at the first visit conducted after the infant turns two**

**months old.** Repeat ASQ-3 screenings at the time intervals specified in the grid in the previous section titled *Using ASQ Scores to Determine What Action the MIHP Provider Should Take*.

Administer the ASQ: SE-2 using the following questionnaire intervals at the times specified below:

- 2 month questionnaire before the infant reaches 3 months old (but not before 1 month of age per the ASQ authors).
- 6 month questionnaire before the infant reaches 9 months old.
- 12 month questionnaire before the infant reaches 15 months old.
- 18 month questionnaire before the toddler reaches 21 months old. (NOTE: You must contact your MIHP consultant for approval to serve a child who reaches 18 months of age.)

If the infant is older than the age limit for a particular ASQ: SE-2 questionnaire at the time of enrollment, use the age-appropriate questionnaire and administer it within the first 3 professional visits.

Do not administer the ASQ: SE-2 at the *Risk Identifier* visit or before the infant is one month old. If it is not possible to administer the ASQ-3 or ASQ: SE at the specified points in time, document the reason in the chart.

Generally speaking, the *Infant Risk Identifier* (which includes developmental screening questions from *Bright Futures*) and the ASQ are **not** administered during the same visit. The *Infant Risk Identifier* is billed as an assessment visit and the ASQ is billed as a professional visit which must be documented on a *Professional Visit Progress Note*. Only under unusual circumstances can these two visits be billed on the same day.

It is not expected that the ASQ-3 and the ASQ: SE-2 will be administered on the same day.

### **Why It's Important to Administer the Initial ASQ-3 and ASQ: SE-2 as Early as Possible in MIHP**

It is important to conduct the initial ASQ-3 and the initial ASQ: SE-2 as early as possible for the following reasons:

1. Many infants are lost to MIHP care after only a few visits. Screening early ensures that these infants will be screened at least once.
2. Many MIHP families, like other families, deeply appreciate the information they get from developmental screening and see it as a real benefit of MIHP participation. Screening appears to be a way to engage some families that would otherwise drop out of MIHP.
3. Children living in poverty are at higher risk for developmental delays than other children. The sooner a developmental delay is identified and early intervention services are initiated, the better. Early intervention increases the probability of a better outcome long term and could positively change the trajectory of the lives of many MIHP infants.

### **Why It's Important to Conduct Repeated Administrations of the ASQ-3 and ASQ: SE-2 in MIHP**

It is important to conduct repeated administrations of the ASQ-3 and ASQ: SE-2 for the following reasons:

1. Child development is dynamic (rapidly changing) in nature.
2. Some developmental delays are not detectable at all stages of development.
3. Repeated developmental screening provides a more accurate assessment of development than a one-time evaluation, and developmental screening at multiple ages allows for monitoring of developmental progress (or regression) over time.

4. Repeated developmental screening promotes and supports a parent's understanding of her child's development.

It is important to screen all children for developmental delays, but especially those who are at a higher risk for developmental problems due to preterm birth, low birth weight, or having a brother or sister with an autism spectrum disorder. (*Centers for Disease Control and Prevention*)

### **Completing and Filing the ASQ-3 and ASQ: SE-2 Information Summaries**

You must complete an *ASQ Information Summary* every time you administer the ASQ-3 or ASQ: SE-2. Note that the *ASQ-3 Information Summary* form is somewhat different from the *ASQ: SE-2 Information Summary* form.

When you complete the *ASQ-3 Information Summary*, you are not required to complete the following fields:

1. Child's ID number
2. The total score column, as long as the total score circles are filled in. (NOTE: As a QA practice, complete both the total score column and the total score circles; but this is not required.)
3. Section 5 Optional

When you complete the *ASQ: SE-2 Information Summary*, you are not required to complete the following fields:

1. Mailing address
2. City
3. State
4. Zip
5. Telephone
6. Assisting in ASQ: SE-2 completion
7. Administering Program/Provider

You must complete all five numbered sections, including Sections #4 and #5, even if the score is below the cutoff (development appears to be on track):

- There are five items under Section #4 – Follow-Up Referral Considerations. Mark each one as Yes, No, or Unsure (Y, N, U). Note that the questions in parentheses are “for example” questions; they aren’t all-inclusive and don’t necessarily have to be addressed for a particular infant. See pages 98-103 in the *ASQ: SE-2 User's Guide* for additional information.
- There are nine items in Section #5 – Follow-Up Action. Check all that apply. If the score is below the cut-off, check “Other:” and write “None.”

At a minimum, the scored *ASQ Information Summary* must be kept in the infant's record for each ASQ-3 and ASQ: SE-2 administered. The completed questionnaire (without the *Information Summary*) should be given to the parent, although a copy of the *ASQ Information Summary* must be provided to the parent upon request.

If the parent doesn't want the completed questionnaire, it may be filed in the chart. This way all home visitors can easily see the specific developmental questions or issues that need to be addressed. However, it is not required that copies of completed questionnaires be kept in charts, as staff may not have portable copy machines for use in the field. Staff who cannot make copies in the field can cross-

reference the scored *Information Summary* to the questionnaire when visiting with the parent, if the parent has kept it.

### **Pulling Infant POC – General Development Based on Bright Futures or ASQ Scores**

The general infant development domain is not required for every infant.

#### Bright Futures Scores

General infant development will score out if a concern is identified by the *Bright Futures* questions in the *Infant Risk Identifier (IRI)*. In this case, you must pull the *Infant Plan of Care – General Development* domain. If no concern is identified by the *IRI Bright Futures* questions, you may pull this domain.

#### ASQ-3 and ASQ: SE-2 Scores

If an infant's ASQ-3 score is below the cutoff or ASQ: SE-2 score is above the cutoff, pull the *Infant Plan of Care - General Development* and add it to the *POC, Part 2*. Also pull *General Development* if there are two consecutive ASQ-3 screenings scoring close to the cutoff (in the gray zone) in the same developmental domain. If the ASQ-3 or ASQ: SE-2 scores out in the gray zone, you may pull *General Development*.

If there are two consecutive ASQ-3 screenings scoring close to the cutoff (in the gray area) in two different developmental domains, and there is no concern on the part of the caregiver or MIHP staff, you need not pull *General Development*. However, be sure to document why you did not do so.

You may pull the *POC 2* whenever you have a concern about an infant's development. If you add a domain to the *POC 2*, follow the regular procedure, including updating and signing the *POC 3* and notifying the medical care provider of this significant change.

In Column 2 of the *POC 2*, the following risk criteria are included:

- ASQ-3 result (s) in gray zone
- ASQ: SE-2 result (s) in gray zone

These statements refer to screening conducted at any time during the course of care, not just to the most recent screening.

### **Learning Activities When ASQ-3 Score is Close to the Cutoff**

New MIHP agencies are expected to purchase the *ASQ-3 Learning Activities* book from the Brookes Publishing Company. Agencies use this resource to teach families how to implement learning activities when an infant scores close to the cutoff (gray zone) in a particular developmental domain.

Brookes describes the 160-page paperback book as follows:

*Enhance the growth and development of infants and young children with more than 400 fun, fast, and easy-to-use learning activities—now in a **new edition** specially developed to complement ASQ-3™. Perfect for sharing with parents of children who are developing typically or need non-intensive support in one or more developmental areas. These playful, developmentally appropriate activities:*

- *Encourage progress in the same five developmental areas as ASQ-3™ - communication, gross motor, fine motor, problem solving, and personal-social*
- *Use safe, age-appropriate materials that most families have at home*
- *Help even the youngest children develop crucial early language and literacy skills*

- *Promote closer parent–child interactions*
- *Serve as a natural follow-up for children who score in the ASQ-3™ monitoring zone*

*New additions include a new set of activities for 0-2 months; more activities - 30+ per age range; more language and literacy activities; more language modeling for parents; easy to email PDF format to share with parents; more differentiation of activities by age; and activities are now in color on the CD-ROM.*

*Now packaged as a book and CD-ROM together so you can photocopy or print them as needed, these creative, cost-effective activities are the perfect way for parents and children to learn and have fun together.*

Use the following process for introducing the learning activities to families:

- Give the family the appropriate Learning Activities sheet, based on the chosen domain and infant's age. (Or, take a cell-phone photo of the Learning Activities sheet and text it to the beneficiary.)
- If older children are present, ask if they would like to learn more about activities they can do with their new brother or sister.
- Explain that these are activities they could do with their infant to help him or her develop.
- Ask if they are already doing some of the activities. If so, provide positive feedback.
- Ask them if they would like you to demonstrate any of the activities for them.
- Ask them if they would like to try doing a learning activity with their infant while you are there.
- Ask them if they would like to try doing a learning activity with their infant in the coming week.
- If so, ask which activity and if they have any questions about it.
- Remind them that infants have to do the same thing over and over and over again to master each little developmental step.
- Provide positive feedback on their willingness to try new things with their infant.
- Make a strength-based comment to the family about what you saw on the visit between the parent and infant.
- At the next visit, follow-up on how the learning activities are going.

The *ASQ-3 User's Guide* also includes Developmental Guide sheets for various age ranges. Developmental Guide sheets provide information about what typically developing infants may be expected to do at each age range. You are not required to share these with families, but it is recommended that you do so.

Although you only are required to provide leaning activities when an infant scores close to the cutoff (gray zone) in a particular developmental domain, it is strongly suggested that you provide learning activities to all families after each ASQ-3 screening, ideally for all five domains. There are several reasons for doing so:

1. Parents may not have access to well-researched infant development information.
2. Parents may use the learning activities to promote their infant's development, strengthening the parent – infant relationship.
3. Parents may appreciate receiving the information which could strengthen your relationship with them and lead them to perceive MIHP as having added value.
4. You would have increased opportunities to provide positive feedback when parents demonstrated or talked about using the learning activities.

### **Learning Activities When ASQ: SE-2 Score is Close to the Cutoff**

MIHP agencies are expected to teach families how to implement learning activities when an infant scores close to the cutoff (gray zone) on an ASQ: SE-2 screening. The *ASQ: SE-2 User's Guide* includes one-page Social Emotional Activities for infants at various age ranges (2, 6, 12, 18, 24 months, and beyond). There is not a separate book of learning activities for the ASQ: SE-2, as there is for the ASQ-3.

The process for introducing the social and emotional learning activities to families is very similar to the process described in the previous section titled *Learning Activities When ASQ-3 Score is Close to the Cutoff*.

Although you only are required to provide learning activities when an infant scores close to the cutoff (gray zone), it is strongly suggested that you provide learning activities to all families after each ASQ: SE-2 screening. The reasons for doing so are given in the last paragraph of the previous section.

The *ASQ: SE-2 User's Guide* also includes one-page Social Emotional Development Guides for infants at various age ranges (2, 6, 12, 18, 24 months, and beyond). Social Emotional Development Guides provide information about what typically developing infants may be expected to do at each age range. You are not required to share these with families, but it is recommended that you do so.

### **Infants Being Screened by Other Early Childhood Providers**

If another early childhood provider is conducting ASQ-3 and ASQ: SE-2 screenings for an infant, the MIHP provider need not duplicate them. Just be sure to document that developmental screening is being provided by another entity and obtain copies of the *ASQ Information Summary* for the infant's record.

If you are unable to secure the *Information Summaries* from the other early childhood program, note the attempts made to do so. You must then conduct the ASQ-3 and ASQ: SE-2 as appropriate from that point forward.

If the infant drops out of the program that has been conducting the screenings, then screening becomes your responsibility. Document that you have asked the caregiver and that the infant is or is not continuing with the program.

When an infant is referred to *Early On*, he or she will receive a developmental evaluation, which is much more comprehensive than ASQ screening, and which will be used to determine eligibility for *Early On* services. If the infant is found to be eligible for *Early On*, an *Individualized Family Service Plan (IFSP)* will be developed and services will be provided. In this case, the MIHP provider need not continue to conduct ASQ screenings, but should document that the infant is receiving services through *Early On*.

If the infant is not enrolled in *Early On* because he is found to be ineligible or the family decides against enrollment, or the infant is enrolled but then drops out of *Early On*, it is your responsibility to resume developmental screening.

### **Adjusting for Prematurity across MIHP Developmental Screening Tools**

All three of the developmental screening tools used in MIHP require adjustment for prematurity:

- When selecting the appropriate *Bright Futures* questions, you need to adjust for prematurity if the infant was born before 40 weeks gestation. Adjusted age is calculated by subtracting the

number of weeks born before 40 weeks of gestation from the chronological age. This adjustment is made automatically when the data is entered electronically into the MDHHS database. However, if you select the wrong questions when you administer the *Infant Risk Identifier*, the screening results won't be valid.

- When selecting the ASQ-3 or ASQ: SE-2 questionnaire to match the child's age, calculate an adjusted age if the child is younger than 24 months at the time of screening and was born 3 or more weeks prematurely. Use the **ASQ Calculator** at [www.agesandstages.com/free-resources/asq-calculator](http://www.agesandstages.com/free-resources/asq-calculator) to quickly and easily adjust for prematurity in order to select the right tool. Use of the **ASQ Calculator** is recommended as it reduces the odds of calculation errors.

### **Developmental Screening with Multiples**

It may not be feasible to complete, score, and discuss the results of ASQ screenings for more than one infant at one visit, especially if developmental guidance is provided. Therefore, in the case of multiples, the MIHP provider may need to conduct developmental screening for each infant at a separate visit.

Since developmental screening is conducted periodically during infancy and screening multiples could take a significant number of visits, the MIHP provider may need to ask the medical care provider to authorize an additional 9 visits. The MIHP provider can only bill under one infant's Medicaid ID number per family for the first 9 visits and for any additional visits authorized by the medical care provider.

When you are serving multiples, you track ASQ-3 and ASQ: SE-2 screening dates on the *Infant Forms Checklist* for the infant whose Medicaid ID is used to bill blended visits. The *ASQ-3 and ASQ: SE-2 Tracking for Multiples* form is used to track screening dates for the other multiples in the family. File the *Tracking for Multiples* form in the chart of the infant whose Medicaid ID is used to bill blended visits or in the family chart.

### **Making and Following-up on Referrals to Other Supports and Services**

MIHP professionals are required to refer beneficiaries to other community service providers as detailed in the interventions for each domain. Professionals are also required to follow-up on referrals to determine whether or not a beneficiary accessed the services to which she was referred. There is an increasing emphasis on tracking referrals and following up on referrals in home visiting initiatives in Michigan and across the country.

### **Agency Referral List**

MIHP agencies must maintain a current list of other agencies that may have appropriate services to offer the beneficiary. This list must be readily available to all MIHP staff.

### **Handing Out Community Referral Information to the Beneficiary**

It is recommended that MIHP providers hand out a community referral list and/or brochures or other written materials to every beneficiary as she enters the program, encouraging her to call the appropriate provider agency if she should require assistance at any point.

## Developing Relationships with Key Referral Sources

There are key referral sources with whom you need to cultivate good working relationships, given the nature of the services they provide and the fact that many beneficiaries need their services. For example, if you do not have a registered dietitian (RD) on staff, your staffing protocol must describe how you arrange for RD services, identify the RD services provider, and specify how and under what conditions the referral is made. Likewise, if you do not have an infant mental health (IMH) specialist on staff, your staffing protocol must describe how you arrange for IMH services, identify the IMH provider, and specify how and under what conditions the referral is made.

You also need good relationships with *Early On*, CMH, MHP behavioral health care managers, substance misuse programs and domestic violence programs, as beneficiaries may be reluctant to use these services and need help to access them. It's not possible to provide quality care coordination in the absence of strong relationships with key referral sources.

## Making Referrals

A referral is considered to have been made when a program staff has identified a need and provided appropriate information to the beneficiary for additional services outside of MIHP. In making a referral, the staff completes the following steps:

1. Discusses a particular referral source with the beneficiary, so she clearly knows what to expect.
2. Encourages the beneficiary to seek services from the referral source.
3. Determines whether the beneficiary wishes to seek services from the referral source. The beneficiary may indicate they have an alternate resource they would like to access.
4. Provides specific information about contacting the referral source in writing.
5. Determines if the beneficiary needs assistance to contact the referral source due to limited English proficiency, low literacy, comprehension difficulties, immobilization stemming from depression, fear or stigma related to using certain services (e.g., *Early On*, mental health services, substance misuse services, domestic violence services, etc.), or other concerns.
6. Provides assistance in contacting the referral source, if needed.

If the beneficiary does not wish to seek services, ask her about her reasons. If appropriate, gently encourage her to continue to think about it, explaining the potential benefits.

MIHP encourages the use of warm transfers when making referrals in some situations. For information on warm transfers, see *Chapter 11 - Maintenance, Retention and Transfer of MIHP Records*.

## Documenting Referrals

Whenever an MIHP professional makes a referral, the appropriate box must be checked under "New referrals" on page 2 of the *Professional Visit Progress Note*. This serves as documentation of the referral and alerts other team members to follow up on it at a subsequent visit.

You now are required to track all referrals, including referrals made over the phone, on the *MIHP Professional Visit Progress Note (PVPN)*. The *MIHP Referral Follow Up Worksheet* has been retired and is no longer available at the website.

If you make a referral over the phone, document it on the *Contact Log*, and then after the next professional visit, document the phone referral on the *Professional Visit Progress Note* in the "New

Referrals” section. This is to help ensure that all referrals made during the course of care are ultimately documented on the *Discharge Summary*.

If you make a referral during the enrollment visit, be sure to document it on the *POC 1* so that it is captured for the *Discharge Summary*.

If the beneficiary declines the attempt at referral, document her refusal of the referral under “Other visit information.” Check intermittently to see if she may be open to the referral at a later date. If the beneficiary is adamant that she does not want the referral, you are not required to bring it up again.

Agencies that provide referrals to their beneficiaries over the phone should document each referral on the *Contact Log* in the beneficiary’s chart. Follow-up on the referral must be documented on the *Professional Visit Progress Note* in the “Outcome of previous referrals” section. Referrals made over the phone must be included on the *Discharge Summary*.

### **Following Up on a Referral and Documenting the Outcome**

Follow-up on a given referral must take place within three professional visits from the date of the referral. Anyone on the team can follow up on a referral; it does not have to be the professional who originally made the referral. The case manager is responsible for monitoring the chart to assure that follow up takes place as required.

An MIHP referral follow-up takes place when a professional:

1. Asks the beneficiary if she has accessed the service to which she was referred.
2. If she has accessed the service:
  - a. Supports her actions in this regard.
  - b. Asks if the service seems to be meeting her needs.
  - c. If it is not, offers any help that may be indicated.
3. If she has not accessed the service:
  - a. Talks with her about why she didn’t access the service (e.g., “baby was sick and I didn’t get to it” or “I ran out of phone minutes” or “I called and they gave me the run-around” or “I changed my mind – I don’t want this service.”)
  - b. If she decided not to seek services, asks about her decision.
  - c. If appropriate, gently encourages her to continue to think about it, explaining the potential benefits.
  - d. If she tried to seek the service, but was unsuccessful, offers to help, if appropriate.

Whenever an MIHP professional follows up on a referral, the beneficiary’s response must be documented under “Outcome of previous referrals” on page 2 of the *Professional Visit Progress Note*. Follow up referral documentation should include which referral is being addressed and the status of the referral.

### **Referrals for Mental Health Services**

In order to provide greater access and to support coordination of care for behavioral health services, the Michigan Department of Health and Human Services (MDHHS) has removed the 20-visit maximum limitation for outpatient behavioral health services (psychotherapy services). The restriction is lifted for both Fee-for-Service and Medicaid Health Plan beneficiaries effective for dates of service on or after October 1, 2017 ([MSA Bulletin 17-27](#)).

## Perinatal Depression

There are three types of depression women may experience during the perinatal period (from start of pregnancy to 12 months after giving birth):

### 1. The Baby Blues

- Common reaction the first few days after delivery
- Crying, worrying, sadness, anxiety, mood swings
- Usually lifts in about 2 or 3 weeks
- Experienced by 50 – 80% of women

### 2. Perinatal Depression

- Major and minor episodes of clinical depression during pregnancy or within first year after delivery
- More than the Baby Blues - lasts longer and is more severe
- Symptoms:
  - Sad, anxious, irritable
  - Trouble concentrating, making decisions
  - Sleeping or eating too much or too little
  - Frequent crying and worrying
  - Loss of interest in self care
  - Loss of interest in things that used to be pleasurable
  - Shows too much or too little concern for baby
  - Not up to doing everyday tasks
  - Feelings of inadequacy
  - Intrusive thoughts
  - Suicidal thoughts
- Symptoms last more than 2 weeks
- Co-occurs with anxiety disorder for 2/3 of women:
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Obsessive-compulsive Disorder
  - Other
- Often co-occurs with substance misuse disorder
- Experienced by 10-20% of all women but prevalence is much higher for low-income and minority women (30 – 60% in various studies)

### 3. Postpartum Psychosis

- A rare disorder (one or two in 1,000 women)
- A severe form of perinatal depression that can be life-threatening
- Symptoms: extreme confusion, hopelessness, can't sleep or eat, distrusts others, sees or hears things that aren't there, thoughts of harming self, baby or others
- A medical emergency requiring urgent care

For much more information on perinatal depression, see the *Implementing the MIHP Depression Interventions* webcast at the MIHP website.

### Developing Relationships with CMHSPs and MHPs to Clarify Referral Process

A significant number of MIHP beneficiaries require referrals for mental health services. MIHP providers need current, accurate information about mental health services available from MHPs, Community Mental Health Services Programs (CMHSPs), and other community agencies that serve Medicaid beneficiaries, including pregnant women and mother-infant dyads. MIHP providers are encouraged to meet with MHPs and CMHSPs in their respective service areas to develop relationships and document the referral process to be used by MIHP providers when referring MIHP beneficiaries to MHPs and CMHSPs for mental health assessment and services.

### Implementing the MIHP Depression Interventions Webcast

Information on making mental health services referrals is included in the *Implementing the MIHP Depression Interventions* webcast. This training, available at the MIHP website, is required for all MIHP professionals.

There are four documents referenced in the webcast that are available at the MIHP website:

1. Possible Reasons for Referral to an MIHP Infant Mental Health Specialist or to CMH for an Assessment
2. Weekly Self-Care Action Plan for Pregnant Women and Mothers with Young Children
3. MIHP Depression Safety Plan (example)
4. MIHP Perinatal Depression Resources for Consumers and Health Care Providers

Two other resources are recommended for sharing with beneficiaries:

1. Depression During and After Pregnancy Fact Sheet  
[Depression during and after pregnancy fact sheet | womenshealth.gov](#)
2. Postpartum Depression Education Video - New Jersey – You Tube (5.13) (video)  
[Post Partum Depression Educational Video \(New Jersey\) - YouTube](#)

### Referring to the Medical Care Provider for Depression Assessment

MDHHS recognizes that although some communities do have perinatal depression treatment programs and/or support groups, the reality is that it is still difficult for many MIHP beneficiaries with depression to access mental health therapy. However, many women are not enrolled in MHPs until fairly late in their pregnancies and their Medicaid coverage ends about 60 days postpartum. Also, in some areas of the state, it is difficult for MHPs to find mental health therapists who will accept Medicaid. Community Mental Health Services Programs (CMHSPs) provide services for Medicaid beneficiaries, but only if they meet criteria for severe mental illness.

Mental health issues are widely prevalent in this country and the vast majority of adults with mental health disorders rely on their primary care providers to make a diagnosis and manage their medications. Approximately 1 in 10 adults are treated with an antidepressant annually, and nearly three quarters of antidepressants are prescribed by general medical providers (Mojtabai R. & Olfson M. (2008) National patterns in antidepressant treatment by psychiatrists and general medical providers: Results from the national comorbidity survey replication (Journal of Clinical Psychiatry, 69(7), 1064-1074). Because of the stigma of mental illness, many people will not see a mental health provider, but will discuss mental health concerns with their primary care provider, so this option may be acceptable to some MIHP beneficiaries.

## MIHP Perinatal Depression Resources for Consumers and Health Care Providers

*MIHP Perinatal Depression Resources for Consumers and Health Care Providers*, available on the MIHP website, is a comprehensive list of resources for consumers and professionals who wish to learn more about perinatal depression and treatment.

The following resources are particularly noteworthy:

### Michigan Statewide Perinatal Mood Disorder Coalition

[www.mipmdcoalition.org/get-help/](http://www.mipmdcoalition.org/get-help/)

The coalition maintains an ever-expanding list of PMD treatment specialists and support groups at the URL above. This list is broken out by 10 regions (State of Michigan Prosperity regions). Many of the specialists listed have indicated which insurances they accept. Find your community on the map of Michigan to identify your region, click on “Get Help” at the top of the page, and click on your region.

You can join with others in Michigan and in your region to support women and families experiencing perinatal mood disorders including, depression, anxiety and others. Coalition membership is free.

### MedEdPPD.org

[www.mededppd.org](http://www.mededppd.org)

A professional education, peer-reviewed website developed with the support of the National Institute of Mental Health (NIMH) to further the education of primary care providers who treat women who have or are at risk for postpartum depression (PPD), and to provide information for women with PPD and their friends and family members. English and Spanish.

### Depression in Mothers: More Than the Blues - A Toolkit for Family Service Providers

<http://store.samhsa.gov>

HHS Publication No. (SMA) 14-4878. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. This free publication, available in English and Spanish, may be downloaded or ordered by phone.

1-877-726-4727.

### Moms' Mental Health Matters

<https://www.nichd.nih.gov/ncmhdp/MMHM/Pages/index.aspx>

National Child & Maternal Health Education Program, Eunice Kennedy Shriver National Institute of Child Health and Human Development. Excellent materials for distribution.

*It's not just postpartum, and it's not just depression. Historically, much of the research on women's mental health related to pregnancy has been on depression that occurs after the birth of a baby. But, we know now—it's not just the postpartum period, and it's not just depression. Women experience depression and anxiety, as well as other mental health conditions, during pregnancy and after the baby is born. These conditions can have significant effects on the health of the mother and her child. This initiative is designed to educate consumers and health care providers about who is at risk for depression and anxiety during and after pregnancy, the signs of these problems, and how to get help.*

## 9.0 MIHP QUALITY MANAGEMENT

### MIHP Provider Certification

The Maternal Infant Health Program (MIHP) monitors and certifies MIHP providers to assure they are operating in compliance with MDHHS policies (Medicaid Provider Manual) and procedures (MIHP Operations Guide). Certification is the culmination of a comprehensive review process, in which the reviewer assesses compliance with both program and billing requirements. Certification reviews are a critical quality component of the MIHP which allows for ongoing performance monitoring, continuous quality improvement and quality assurance.

### Certification Consultation

MIHP state consultants provide periodic consultation to assist all new MIHP providers to prepare for their first certification review. All new MIHP providers are required to participate in these consultation visits. Failure to participate in either one of these visits will result in cancellation of the review.

Existing providers with conditional certification must participate in at least one onsite consultation visit prior to their next review. Existing providers with full 18 month or 36 month certification may request a telephonic consultation upon request.

### Review Timeline for New Providers

MDHHS grants a new provider a six-month provisional certification upon completion of all new provider training requirements and the initial onsite consultation. The initial certification review is conducted approximately six months after the provisional certification is granted. A new provider who receives conditional certification at their first review is reviewed again in nine months. A new provider who receives 18 or more not-met citations will be decertified and terminated as a MIHP provider.

### Review Timeline for Existing Providers

An existing provider who receives full certification is reviewed again approximately 18 or 36 months, depending on the number of not-met citations, after this review. An existing provider who receives conditional certification is reviewed again in nine months. An existing provider who receives 18 or more not-met citations will be decertified and terminated as a MIHP provider.

### Minimum Caseload Requirements in Order to be Reviewed

In order to be reviewed, new and existing agencies must have at least 40 client charts. This may be any combination of open and closed charts that were active for some period of time since program start-up or in the last 12 month period. If closed charts are included in the 40, they must have been closed during this period of time.

The only MIHP agencies that are not required to have 40 charts at the time of certification review are tribal agencies that have been designated as exempt by MDHHS.

To ensure that a new provider will have 40 cases by the time of the first review, it is recommended the provider meet minimum caseload expectations at two points in time prior to the review. The assigned MIHP state consultant contacts the new provider at the times specified below to inquire about the number of beneficiaries enrolled in the MIHP to date and, if applicable, discharged since the agency received provisional certification:

It is expected that a new provider have:

At least ten beneficiaries one month before review

At least 35 beneficiaries two weeks before review

\* Please note: No more than 10 beneficiary transfers can be counted toward the 40 cases required for a new provider's initial review.

The state consultant will ask the new provider to submit beneficiary counts in writing at these points in time. The information documented by the provider will be cross-checked through administrative data.

Existing providers must have at least 40 beneficiaries in the twelve months before the review.

The new provider's first certification review is scheduled about six months after provisional certification status is granted. One week before date of the 6-month mark, all new providers must have 40 charts, regardless of the scheduled date of their upcoming review. This requirement is to ensure that all new providers have the same number of weeks to enroll 40 beneficiaries.

Cases that are ready for discharge should not be kept open.

### **Overview of the Certification Process**

The certification review is conducted in two parts:

1. Pre-review. The first part is a review of documents submitted by the provider and received by the reviewer at least 14 calendar days prior to the scheduled onsite review. Timely submission of pre-review documents is measured in indicator #38 of the *Cycle 7 Certification Tool*. The required pre-review documents are included in the certification scheduling letter sent when the review is scheduled. This information is also listed in the Certification Tool under the title "pre-review documents."
2. Onsite review. The second part is a two-day onsite visit, during which the reviewer conducts staff and coordinator interviews; observes the agency; examines open and closed beneficiary charts; examines billing documentation; and conducts a brief exit meeting.

The review is conducted by a registered nurse or a licensed social worker who has worked, or is currently working, as an MIHP program coordinator or professional staff.

For an overview of the certification process with timeframes, the following documents can be accessed on the MIHP website:

1. MIHP Certification Review Process Flow – Existing Agency
2. MIHP Certification Review Process Flow – New Agency

### **Types of Certification**

#### **Provisional Certification**

MDHHS grants a new MIHP provider a six-month provisional certification upon completion of all new provider training requirements and the initial onsite consultation. The initial certification review is conducted approximately 6 months after the provisional certification is granted. Provisional certification allows the new agency to begin to serve beneficiaries and submit billings.

### Conditional Certification

Conditional certification is obtained when:

- A new agency has had their first certification review (all new agencies receive a conditional certification after their first review).
- An existing agency has received 7 to 17 *Not Met* indicators or three or more *Not Met* critical indicators.
- The agency has submitted a Corrective Action Plan for the *Not Met* indicators and MDHHS has approved it. The CAP must be received by MDHHS within 21 calendar days of the official notification of the results of the review. MDHHS responds approximately two weeks from the date of receipt of the CAP, approving the CAP or requesting modifications.

Conditional certification is effective for 9 months, during which time the agency must correct all *Not Met* indicators. Conditional certification requires a follow-up consultation visit at approximately three months. Depending on the number, complexity and critical nature of the *Not Met* indicators, this visit may be scheduled earlier than three months post review.

Approximately 9 months after the first conditional review, a second review is conducted. For existing agencies, the outcome of the second review is either full certification or decertification. For new agencies the outcome of the second review is either a second conditional certification, a full certification or a decertification.

### Full 18 month Certification

Full 18 month certification is obtained when:

- The agency has received 6 or fewer *Not Met* indicators, two or fewer of which are critical indicators.
- The agency has submitted a Corrective Action Plan (CAP) for the *Not Met* indicators and MDHHS has approved it. The CAP must be received by MDHHS within 21 calendar days of the official notification of the results of the review. MDHHS responds approximately two weeks from the date of receipt of the CAP, approving the CAP or requesting modifications.

Approximately 18 months after the Full 18 month review, the next review is conducted.

### Full 36 month Certification

Full 36 month certification is obtained when:

- The agency has met all of the following conditions:
  - 3 or fewer *Not Met* indicators,
  - zero *Not Met* critical indicators,
  - 3 or less *Met with Condition* indicators; and
  - zero *Met with Conditions* critical indicators.
- The agency has submitted a Corrective Action Plan (CAP) for the *Not Met* indicators and MDHHS has approved it. The CAP must be received by MDHHS within 21 calendar days of the official notification of the results of the review. MDHHS responds approximately two weeks from the date of receipt of the CAP, approving the CAP or requesting modifications.

Approximately 36 months after the Full 36 month review, the next review is conducted.

## Decertification

Decertification takes place under one of the following circumstances:

1. A new or existing agency receives 18 or more *Not Met* indicators at any review.
2. An existing agency receives 7 or more *Not Met* indicators or 3 or more *Not Met* critical indicators at two successive reviews.

Decertification requires the agency to cease providing MIHP services. When an agency is decertified by MDHHS, the agency's certification to provide or be reimbursed for MIHP services is revoked and upon notification, the agency must immediately cease enrolling beneficiaries. A written notice is sent to the agency via certified mail.

The certified letter includes: the date of decertification; the requirement to stop enrolling beneficiaries in the MIHP; the requirement to close or transfer the active caseload to another MIHP provider within 14 business days of receipt of the letter; suspension of any future billings for services from the date of decertification on; and notice of removal from the MDDHS *MIHP Coordinators Directory*.

Written notification to the MDHHS MIHP Consultant that the termination plan was successfully implemented is required no later than 30 days after the agency's termination date.

An agency that is decertified may file an appeal via the Medicaid Administrative Tribunal and Appeals Division. The Medicaid Policy Consultant, Medicaid Managed Care and Medicaid Claims are informed when an agency is decertified.

The *MIHP Decertification Termination Protocol* is available at the MIHP website.

## Emergency Decertification

An emergency decertification may be authorized if a certification review or a complaint investigation reveals a serious action/inaction or a pattern of activity that threatens the health, well-being or safety of Maternal Infant and Health Program beneficiaries. Emergency decertification can be invoked in conjunction with the MDHHS Office of Inspector General (OIG), which is responsible for investigating alleged Medicaid fraud, waste, and abuse. In this situation, the agency may be shut down immediately, rather than within 30 days after a specified termination date.

An agency that is decertified on an emergency basis may file an appeal via the Medicaid Administrative Tribunal and Appeals Division.

## Certification Review Scheduling

The MIHP certification reviewer is assigned 4-6 weeks before a review and will contact the agency at that time to schedule the actual dates of the onsite review. Onsite reviews are conducted on two consecutive week-day dates. However, in rare instances an onsite review may be conducted on the weekend, at the discretion of MDHHS.

The MIHP agency will know the approximate month of their review based on the type of certification attained at the previous review. The certification review is scheduled by the assigned reviewer approximately 9, 18, or 36 months after your previous review.

The MIHP program coordinator must be available for the entire review. Your agency must have a back-up person who is prepared to substitute for the MIHP program coordinator in the event that the MIHP

program coordinator has an emergency on the days of the review and cannot participate. A review will not be re-scheduled in case of coordinator emergency due to cost considerations. Please have additional staff on hand to assist (e.g., answer questions, locate charts and other documents, etc.), if needed.

Shortly after the review is scheduled, the provider receives the *MIHP Certification Review Scheduling Letter – New Provider* or the *MIHP Certification Review Scheduling Letter – Existing Provider*. These letters describe in specific detail what the provider needs to do to prepare for the review, including what materials are required to be submitted to the reviewer prior to the onsite review. The deadline for receipt of these materials is indicated on the letter (14 calendar days before the onsite review).

Indicator #38 measures timeliness and completeness of the pre-review materials. Be sure to double-check that you have compiled all of the pre-review materials before you send them to the reviewer. It is not the reviewer's job to track them for you and let you know if something is missing.

The provider is encouraged to use the *Certification Tool* and *Chart Review Tools* (discussed in *Standardized Chart Review Tools* section later in this chapter) to review their own program prior to the certification review visit, so they are as prepared as possible for the onsite review.

Note that conducting internal chart reviews is a criterion for Indicator #66 on the *Certification Tool*. Although it is not mandatory that you use the *MIHP Chart Review Tools* for internal reviews, you are required to keep a file of the completed chart review tools that you have used within the last quarter to present to your reviewer.

### **Selection of Charts for Review**

The MIHP Quality Improvement team selects the charts for both the program and billing portions of the certification review for new and existing agencies. A desk audit is performed prior to the review to identify which charts are to be reviewed.

For billing review charts, claims data are examined. Charts with identified billing discrepancies are selected first, and then random selection is used for the remaining charts. Examples of billing discrepancies include, but are not limited to:

- More than one *Risk Identifier* was billed per beneficiary
- Professional visits were billed before the *Risk Identifier* was billed
- More than 9 maternal visits were billed
- More than 9 infant visits were billed without authorization of the medical care provider
- *Infant Risk Identifier* was administered on an infant over 12 months of age without consultant's written approval
- Infant over 18 months of age was served without consultant's written approval

For program review charts, claims data are examined. Charts with potential program discrepancies are selected first, and then random selection is used for the remaining charts.

This means that:

1. Your agency will not have advance notice of the charts that have been selected for the billing review.
2. When the reviewer arrives at your office, she will hand you a list of the beneficiary names whose charts you will pull for the billing component and for the program component of the review. The

list of names will also include Medicaid ID numbers. The billing chart review consists of 6 maternal charts and 6 infant charts. The program chart review consists of 7 maternal charts (4 open and 3 closed) and 7 infant charts (4 open and 3 closed).

3. All charts and billing records must be presented by **10:00 am on the first day of the review** to the reviewer, or the review could be cancelled.
4. If your existing agency has more than one MIHP office, your review will not be conducted at the main office; it will be conducted at the satellite office serving the greatest number of MIHP beneficiaries. Only charts from this satellite office will be reviewed. You will be asked to submit to the reviewer with the review packet, a list of all beneficiaries served at the satellite office in the 12 months prior to your review. The list should contain for each beneficiary:
  - a. Name
  - b. Date of Birth
  - c. Medicaid Number

### Onsite Review

The MIHP agency must have a back-up person prepared for the review in case the coordinator has an emergency and cannot participate in the review. A review will not be re-scheduled in case of coordinator emergency because of cost considerations.

The onsite review includes:

1. Coordinator interview
2. Professional staff group interview (except at a nine-month follow-up review)
3. Billing review of open and closed charts since last review
4. Discussion of findings from review of submitted documents
5. Program review of open and closed charts (since last review)
6. Follow-up on any *Not Met* indicators from last review (if applicable)
7. Agency observation
8. Exit meeting and signing of *MIHP Certification Review Confirmation Form*

If the provider has an electronic health records system, the coordinator indicates if they will print out paper copies of the selected charts or if they will assign a staff to assist the reviewer to review the charts electronically.

### All Charts Must be Presented to Reviewer by 10:00 AM on Day One of Review

As indicated in your review scheduling letter, when the reviewer arrives on the first day of the review, you will be provided with a list of the beneficiary names whose charts you will pull for the billing component and for the program component of the review. You must give the reviewer all of the paper charts or access to all of the electronic charts by 10:00 am on Day 1 of the review or the review could be cancelled immediately and your certification automatically expire.

### Professional Staff Group Interview

The group staff interview is conducted at every review, except for 9-month follow-up reviews. The interview takes approximately one hour. The number of professional staff who must be present (in addition to the coordinator) depends on the size of the staff as noted below:

1. Agency employing 2-3 professional staff: All must participate.
2. Agency employing 4-5 professional staff: At least three must participate.
3. Agency employing 6 or more professional staff: At least 50% must participate.

If professional staff cannot participate in the group interview in person, they may participate via conference call. Failure to have the required number of professional staff participate in the interview will result in a *Not Met* citation for that indicator.

Administrators and other program staff are welcome to observe the staff interview. Only persons who are listed on the *MIHP Personnel Roster* may actively participate in the staff interview.

### Standardized Chart Review Tools

During the onsite review, the reviewer uses standardized chart review tools to document her findings. The provider is encouraged to use these tools as they conduct their own internal quality assurance chart reviews. The tools are all available at the website:

1. Program Chart Review Tool
2. Sample of the “unpopulated” Billing Review Tool

### Exit Meeting

At the end of the certification review, the reviewer will briefly discuss strengths and general areas of concern, and answer any questions that the MIHP program coordinator and staff may have regarding the review. The reviewer will then present the *MIHP Certification Review form*. This form indicates when to expect receipt of *Preliminary Findings* and when to expect the final certification results. It also lists all of the records that have been copied for the reviewer to take off-site (if applicable), and provides spaces for the signatures of the reviewer and MIHP program coordinator, verifying agency participation in the review.

### Preliminary Findings

Within five business days from the last day of the review, the agency will receive the *Preliminary Findings of Not Met Indicators* from the reviewer in writing via email. The reviewer’s findings are preliminary because the final determination is made by the MDHHS MIHP Quality Improvement team. However, corrective actions should be initiated immediately for each of the *Not Met* indicators identified on the *Preliminary Findings* form.

Within approximately 45 days of the review, the agency will receive a certification status notification letter. It will state that within 21 days of receipt of the letter, the agency must submit a *Corrective Action Plan* addressing each *Not Met* indicator as listed in the notification letter.

### Post-Review Preparation of Certification Documents

After the onsite review is concluded, the reviewer drafts two documents:

1. *Certification Report*, which includes findings from all of the “Not-Met” and “Met with Conditions” ratings. If you received a “Met” or a “N/A” for an indicator they will not be indicated on the report.
2. *Certification notification letter*, which identifies the *Not Met* and *Met with Conditions* indicators and gives the certification status.

The reviewer submits these documents, along with the *Preliminary Findings of Not Met Indicators*, to MDHHS. When MDHHS receives the documents, they are reviewed by the MIHP quality improvement team. This team may or may not entirely concur with the reviewer’s findings, which is why the preliminary findings are tentative.

### Notification of Review Results

Within 45 days after the review is completed, the following certification documents are emailed to the provider (templates available at MIHP website):

1. Certification Notification Letter
2. Certification Report (with “Not-Met” and “Met with Conditions” ratings and comments)
3. Corrective Action Plan (CAP) and Instructions (if applicable)

### Corrective Action Plans

If one or more indicators are rated as *Not Met*, the provider must submit a *Corrective Action Plan (CAP)* to MDHHS within 21 days of receipt of the certification notification letter, using a standardized form and set of instructions. Upon receipt of the CAP, MDHHS has 14 days to respond.

When MDHHS receives the CAP, it is reviewed by the MIHP quality assurance coordinator, MIHP quality improvement coordinator, and the state consultant. This team approves the CAP or determines that modifications are needed. If modifications are needed, the consultant informs the agency. The agency then must resubmit the CAP within 2 business days. The provider receives written notice when the CAP has been approved.

### Ensuring All Consents and Plans of Care are Complete and Accurate Post Review

If Indicator #3 (consents) or Indicator #27 (*Plan of Care, Part 2*) were rated Not Met, the first team member to visit a beneficiary subsequent to the review, must check to make sure that the consents or the POC 2 are complete and accurate before conducting the visit. For example, if #27 was rated *Not Met* because chart review indicated that some domains that scored out as risks on the *Risk Identifier* did not have corresponding POC 2 domains in the chart, the team member needs to check the POC2 for accuracy and if needed, add the missing domains to the POC 2 to ensure the beneficiary will get the appropriate care. In this case, the team member also needs to notify the medical care provider that additional risks have been identified.

### Billing Concerns Referred to MDHHS Office of Inspector General

When a certification review identifies potential billing concerns, the certification documents are forwarded to the MDHHS Office of Inspector General (OIG). The OIG audits and investigates suspected misuse of Michigan’s Medicaid Program to ensure that funds are used for the best care of beneficiaries. The OIG recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation and prosecution.

### Confirmation Emails Required throughout Certification Process

Providers receive numerous documents from MDHHS throughout the certification review process, including the review scheduling letter, certification documents and Corrective Action Plan approval letter. Providers must confirm receipt of each of these documents by sending an email to mailbox:

[MDHHS-MIHPCertification@michigan.gov](mailto:MDHHS-MIHPCertification@michigan.gov)

### Tips for Agencies Preparing for Certification Review

1. Become very knowledgeable about the *MIHP Certification Tool* NOW. Don’t wait until your review is imminent. The *Certification Tool* will help you understand what you need to do in order to be fully certified at your next review.
  - a. Carefully study every single indicator and criterion.
  - b. Ask your MIHP consultant to clarify anything you don’t understand.

- c. Ask your MIHP consultant for ideas on how to meet the criteria; consultants have knowledge and experience working with various MIHP providers who've set up good systems. Don't waste time wondering what you're supposed to do or reinventing the wheel.
2. Pay special attention to the *Top 10 Not Mets*, especially the MIHP critical indicators that are shared at every MIHP program coordinator meeting.
3. Conduct your own practice certification review. The tools used by the reviewers are on the website.
4. Ask your MIHP consultant questions. Your consultant is available to answer your questions and help you understand the program and its ever-changing requirements, so that your MIHP will succeed.
5. Whenever the MDHHS Perinatal Health Unit Technician sends you an email asking that you confirm receipt, be sure to reply immediately.

### Internal Quality Management

It is required that MIHP providers do not rely solely on MDHHS certification reviews in order to assure and improve program quality. MIHP program coordinators are expected to routinely conduct their own internal quality assurance and improvement activities, including chart reviews and billing audits.

The purpose of internal quality management activities is to assure that: documentation is complete; POCs are being implemented; appropriate referrals are being made and followed-up on; and all staff are following the program requirements specified in the *Medicaid Provider Manual* and the *MIHP Operations Guide*.

MIHP providers must have an internal quality management protocol that:

1. Describes internal quality assurance activities
2. Specifies that chart reviews and billing audits are conducted quarterly, or more frequently
3. Specifies which staff position(s) performs chart reviews and billing audits
4. Indicates the minimum number of charts reviewed per chart review and per billing audit
5. Describes how staff are trained and supported to ensure that the *Risk Identifier*, *POC*, *Professional Visit Progress Notes*, and *Discharge Summaries* are linked
6. Describes how staff works with the beneficiary to identify her needs at program entry and periodically asks beneficiary if services being provided are meeting her needs
7. Describes how quality assurance results will drive quality improvement activities

At the time of certification review, the reviewer will look at completed standard forms, checklists or other tools used in the last quarter's internal chart review and billing audit, to determine whether or not reviews and audits actually are being conducted.

The MIHP program coordinator is responsible for implementing the internal quality management protocol. If deficiencies are identified through this process, the coordinator is also responsible for developing a quality improvement plan, overseeing implementation of the plan, and evaluating whether or not the plan worked.

The *Maternal and Infant Forms Checklists* are intended to assist you with internal monitoring. They are the only place to document some MIHP activities, and they provide the recommended order of document placement in charts. It is not acceptable to prepare the *Forms Checklists* only for the charts that will be reviewed by MDHHS.

## Addressing Potential Deficiencies between Reviews

Whenever the MIHP program coordinator experiences difficulties in delivering services to a beneficiary or encounters significant barriers to implementing a particular policy or protocol, the coordinator is encouraged to contact an MIHP consultant to discuss the situation. The consultant will carefully evaluate all of the factors involved and assist the coordinator to resolve the situation if at all possible so that the program is not cited with a deficiency.

## Unannounced Site Visits

On rare occasions, MDHHS MIHP staff will make an unannounced site visit to an MIHP agency. The MDHHS Office of the Inspector (OIG) also makes unannounced visits. Unannounced visits typically take place for one or more reasons:

- A whistleblower reports possible fraud/abuse
- A beneficiary lodges a complaint of a serious nature about the quality of services received
- Another entity lodges a complaint of a serious nature, including unethical behavior
- There are unusual or questionable findings in a certification review
- Questionable financial activity is identified through a MDHHS in-house billing audit, which is separate from certification billing review
- Concerns are identified by an MDHHS employee and the MDHHS Perinatal Health Unit Manager determines that they are of a serious nature

Medicaid providers must, upon request from MDHHS, make available for examination and photocopying, any record that they are required to maintain. This means that MIHP documents must be appropriately filed in the beneficiary's chart at all times, not just in preparation for a certification review.

## MIHP Quality Improvement

Coordinators are encouraged to learn as much as possible about Continuous Quality Improvement (CQI). CQI is a process-based, data-driven approach to improving the quality of a service or product. The federal government's Health Resources and Services Administration (HRSA) has a quality improvement toolkit online that is helpful when implementing the QI process and can be accessed at <https://www.hrsa.gov/quality/toolbox/methodology/index.html>

Proven processes, such as Plan, Do, Check, Act, (figure 1), can be utilized to assist with quality improvement projects in MIHP agencies. There is always room for improving operations, processes, and activities so that the best and highest quality of care is provided to mothers, their infants and families enrolled in the MIHP.

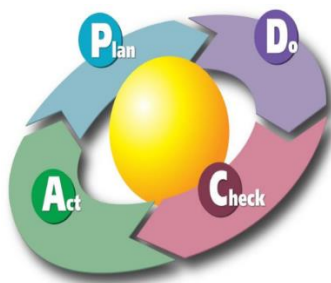


Figure 1

**Plan** – Recognize and analyze the problem needing improvement

**Do** – Develop and test the solution

**Check** – Review the test and study the results

**Act** – Take action based on what you learned in the study step: Adopt, adapt, or abandon

Modified from Demming's PDSA

Accessed at <http://asq.org/learn-about-quality/project-planning-tools/overview/pdca-cycle.html>

PDCA picture – Wikipedia, the free encyclopedia, accessed at <https://en.wikipedia.org/wiki/PDCA>

**Meeting Beneficiary Needs and Expectations Matters**

An important measure of quality is the extent to which patients' needs and expectations are met.

(Health Resources and Services Administration, US Department of Health and Human Services)

In MIHP, we are always striving to improve our ability to meet beneficiary needs and expectations. We do this by:

- Supporting beneficiary engagement
- Asking beneficiary about her service priorities
- Practicing with cultural humility
- Providing linguistically appropriate care
- Assessing health literacy
- Engaging in beneficiary-centered communication
- Using Motivational Interviewing
- Asking beneficiary for feedback on satisfaction with services at the end of each visit
- Providing evidence-based care
- Coordinating care with other parts of the larger health care system

**MIHP Quality Improvement Over Time**

As our understanding and practice of continual quality improvement matures, so will MIHP program fidelity. Fidelity is vital to the survival of the MIHP program because it provides accountability to stakeholders. Improved quality improves the health and well-being of Medicaid eligible pregnant women and infants.

## SECTION 10 - MIHP PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING

MIHP is a complex, comprehensive program. In order to promote program fidelity and to keep providers updated on new developments, MDHHS offers a range of consultation, technical assistance and training activities.

### MDHHS Consultation

MDHHS MIHP consultants have specialized expertise and knowledge about MIHP and are available to provide you with assistance and advice. Consultation activities for agencies include but are not limited to:

#### 1. Individual Calls or Meetings with MDHHS MIHP Consultants

MDHHS MIHP consultants are available to respond to providers' individual questions and to assist them with problem solving on an as-needed basis. Consultants make every effort to respond to inquiries as soon as possible and welcome dialogue with providers. It is expected that the MIHP program coordinator is the only one who communicates agency needs and concerns to the MDHHS consultant. Communications should not come from multiple staff.

While MIHP providers are encouraged to network with each other and grow together as a community, providers are cautioned against relying on other providers for answers to their questions. When you have questions about Medicaid policy, the *MIHP Operations Guide*, or MIHP forms and forms instructions, it is best to direct them to your consultant.

#### 2. Direct Mail and Email Communications

MDHHS periodically provides written program updates, policy and procedure clarifications, and resource information to MIHP program coordinators via email or direct mail.

Coordinator emails generally are sent on a monthly basis to MIHP program coordinators and Medicaid Health Plans. The emails are dated and numbered for reference purposes. When asking an MIHP consultant for clarification on a particular email message, it's helpful if the provider can give the date and number of the message in question, although it is not required.

Copies of previous coordinator emails may be accessed through the MDHHS-MIHP File Transfer areas of the MILogin System. File Transfer allows MIHP providers to secure web-based access to vital program-related communications 24 hours per day, seven days per week. A maximum of two staff members per agency may request subscriptions to File Transfer areas.

MDHHS issues a list of topics that have been covered in coordinator emails two times a year.

IT Alerts are email messages that are sent to MIHP program coordinators to inform them that IT issues affecting the State of Michigan MIHP computer applications have been identified or resolved. The alerts are usually time-sensitive, so they are sent separately from the monthly coordinator emails.

## MDHHS Technical Assistance

MDHHS staff offers technical assistance with data, electronic forms, and navigating MDHHS technology including, but not limited to:

### 1. Data

The MDHHS vision is to promote better health outcomes, reduce health risks and support stable and safe families while encouraging self-sufficiency. The MIHP assists in the success of this mission through supporting Medicaid beneficiaries in order to promote healthy pregnancies, positive birth outcomes, and infant health and development. Statewide and agency-specific data informs the program to accomplish this goal.

Data is gathered from various sources including Medicaid paid claims, *MIHP Risk Identifiers* and *MIHP Discharge Summaries*. MIHP data is analyzed to assure proper utilization of services and provide objective information for MIHP providers, MDHHS, legislators, and other stakeholders.

MIHP has established data standards and processes to ensure data integrity, confidentiality, and security. Our goal is to maintain accurate, standardized data while protecting the data from inappropriate use.

### 2. MIHP Provider Quarterly Data Reports

MDHHS provides each MIHP provider with quarterly reports based on data that the provider has entered into the MIHP electronic database. The MIHP provider can use these reports to plan program changes to improve service quality. Reports include: Demographics, *Risk Identifiers* completed; *Discharge Summaries* completed; *Risk Identifier* domain scores; referrals made; education provided; and breastfeeding data.

Effective July, 2015, the data reports for MIHP provider agencies are generated quarterly and pushed electronically to each provider's inbox within the CHAMPS billing system. Any MIHP provider who has access to CHAMPS can view, save, and/or print their MIHP agency quarterly data reports from the "Archived Documents" area of their CHAMPS inbox.

MIHP reports are auto-generated and become available the first week of the month following the end of each quarter (mid-January, mid-April, mid-July, and mid-October). MIHP quarterly data has a six-month claims lag time to allow for data completion in the Michigan Data warehouse system.

Quarterly Data Report Schedule:

<u>Data Period</u>	<u>Distribution Period</u>
<b>Q1</b> (Oct – Dec)	Distributed to CHAMPS agency inboxes <b>1<sup>st</sup> week in July</b>
<b>Q2</b> (Jan – Mar)	Distributed to CHAMPS agency inboxes <b>1<sup>st</sup> week in October</b>
<b>Q3</b> (Apr – June)	Distributed to CHAMPS agency inboxes <b>1<sup>st</sup> week in January</b>
<b>Q4</b> (Jul – Sept)	Distributed to CHAMPS agency inboxes <b>1<sup>st</sup> week in April</b>

To locate your agency's quarterly data reports in CHAMPS:

- Login to MILogin: <https://milogintp.michigan.gov>
- Click on the CHAMPS application link.

- c. Select your profile (in order to query documents you must select CHAMPS Full Access or CHAMPS Limited Access) > click Go.
- d. Once at the main CHAMPS screen, click My Inbox > click Archived Documents.
- e. Click on the Go button to retrieve results.
- f. You can narrow your search by selecting an item (i.e., Received Date, Payroll Date) from the “Filter By” drop-down list(s) and then enter the specific criteria in the field(s). For date selections you will need to enter a “from date” and “to date” (both red boxes) in a MM/DD/YYYY format > then click the Go button.
- g. In order to view a document, double-click on the Document Name.
- h. A File Download window may appear depending on what format (i.e., PDF, Excel, Word) of file you are opening. Click Open to open the file and click Save to save the file.
- i. Note: columns with up and down arrows allow you to sort ascending or descending.

### 3. MIHP MILogin System File Transfer Areas

The MDHHS - File Transfer application is a web-based application accessed via internet browser through the State of Michigan MILogin System. The name of the file at present is listed as DCH-File Transfer.

The DCH-MIHP File Transfer area houses official MIHP communications generated by the State of Michigan Maternal Infant Health Program. Current and historical records are available for download. When new documents are posted by State MIHP staff to the MIHP File Transfer area(s), an email is automatically generated by the File Transfer system announcing that a File is available for download.

A User ID and Password for the MILogin System are required to access the DCH-MIHP File Transfer areas and MIHP providers must request a subscription through the MILogin System to access the MIHP File Transfer areas. A maximum of two staff members per agency may request a subscription to each of the MIHP File Transfer areas.

There are two MIHP File Transfer areas:

1. One is titled, *MIHP Coordinator Emails*. This area houses all MIHP program coordinator emails from the following fiscal years:
 

FY 2013/14	Entire Year of Reports #01 - #21
FY 2014/15	Entire Year of Reports #01 - #11
FY 2015/16	Partial Year to Current
2. The other is titled, *MIHP Quarterly Reports*. This area houses historical Quarterly Data Reports from FY 2013 and FY 2014. Beginning with the first quarter of 2015, Quarterly Data Reports are made available for all providers in the CHAMPS system under the provider inbox.

MILogin System Issues:

- If you have any problems accessing your MILogin System account, please contact State of Michigan Client Service Center at 517-241-9700 or 1-800-968-2644.

DCH-File Transfer Application Issues:

- If you have problems accessing the MILogin System DCH-File Transfer link, please contact the State of Michigan Client Service Center at 517-241-9700 or 1-800-968-2644.

MIHP File Transfer Area Issues:

- If you have problems subscribing to or downloading from the MIHP File Transfer Areas, please contact your MIHP Consultant.

#### 4. Certification Data Reports

MIHP utilizes standardized data reports as part of the MIHP agency certification process. Prior to agency certification review, data reports are generated to obtain an 18-month historical record of the agency's MIHP Medicaid claims. This information is used in the desk audits performed by the MIHP Quality Improvement Coordinator and the MIHP Reviewer prior to the agency's onsite review.

#### 5. Data Requests

From time to time, an agency will request additional data from the MDHHS MIHP database to address a particular question. Contact your consultant when you have a data request. You may be asked to complete and submit a data request form, depending on the complexity of your request. The completed data request form will be reviewed and approved or denied, based on the following factors:

- Date the data is needed
- Reason the data is being requested
- Availability of the data requested
- MIHP staff availability to compile the data

#### 6. Acceptable Browsers for MIHP MILogin System

The acceptable browser for MIHP MILogin use is IE 11. **You cannot use IE 9 or 10.** Occasionally, Internet Explorer (IE) will auto-update to another level. You should always check the printed version of your *Risk Identifier* and *Discharge Summary* for accuracy.

#### 7. MIHP Agency NPI Issues

MIHP agencies are required to use only one NPI number for all MIHP business since the agency's NPI number affects MIHP data results. An MIHP agency that has been using one NPI number to enter *MIHP Risk Identifiers* into the MILogin System MIHP application and another NPI to perform their MIHP billing via CHAMPS claims must contact MDHHS to rectify this issue.

### Training

#### 1. MIHP Community of Practice Calls

MIHP Community of Practice Calls are facilitated by MDHHS for all MIHP coordinators and staff every other month. The 2-hour calls cover MIHP and Medicaid updates, policy and procedure clarifications, and presentations on topics relevant to MIHP practice. Participants in the field are invited to submit questions online during the call. All MIHP agency staff are encouraged to participate in these calls.

#### 2. MDHHS Online Trainings

MDHHS has developed a series of online trainings for MIHP providers. These trainings are for all MIHP program coordinators and all professional staff paid with MIHP funds to work directly with beneficiaries. Trainings can be accessed at the MIHP website under the heading *MIHP Provider Training*.

Some of the trainings are required and some are optional. The required trainings are clearly designated as such on the website. There are four categories of training:

- a. Required Training for All MIHP Provider Applicants
- b. Required Training for All MIHP Staff
- c. Additional MIHP Provider Trainings
- d. MIHP Domains/Risks and Provider Education

MIHP providers should strongly encourage their staff to complete the optional trainings, as well as the required trainings. Completion of trainings should be documented in personnel files.

Administrative staff who enter data into the MIHP database are required to view the online training titled *Overview of the MIHP Training Course* (formerly titled *MIHP Billing and Overview*).

Training certificates for the required trainings must be submitted at the time of certification review. Certificates must be obtained and printed by attendees and placed in agency files. Only the participant can retrieve a certificate from the portal. Coordinators and reviewers are not able to use this tool to look up employee certificates.

Copies of training certificates earned prior to October 1, 2016, may be obtained from your consultant. Training certificates earned after that date must be accessed through the MPHI continuing education portal.

Agencies are responsible for accessing the portal and printing certificates. Links to the continuing education portal and the portal instructions are provided below:

CE Portal:

[https://mph-web.ungerboeck.com/wri/wri\\_p1\\_display.aspx?oc=10&cc=CEDATA](https://mph-web.ungerboeck.com/wri/wri_p1_display.aspx?oc=10&cc=CEDATA)

Portal Instructions:

[https://mph-web.ungerboeck.com/wri/wri\\_p1\\_display.aspx?oc=10&cc=10&cc=CEHIS](https://mph-web.ungerboeck.com/wri/wri_p1_display.aspx?oc=10&cc=10&cc=CEHIS)

The coordinator may choose to have the staff view an online training as a group in order to discuss it. In this case, the sign-in sheet will serve as documentation of completion for certification review purposes.

Required trainings need to be completed just once, as long as you have the certificate of completion (or sign-in sheet for a group). However, repeating one or more trainings may be part of an agency's *Corrective Action Plan* subsequent to a certification review. All staff persons are encouraged to review the trainings whenever they feel they need a refresher.

Continuing education contact hours for licensed registered nurses and licensed social workers are available for some of the MDHHS online trainings. Completion of a survey is required. It may take several weeks to receive the CEs.

### 3. Required Training for New Professional Staff

All new MIHP staff (hired or contracted) are required to complete the training activities specified on the first page of [New and Waived Employee Training](#). The new staff and supervisor must both sign the [Notice of New Professional Staff Training Completion](#) and it must be placed

in the staff's personal file. Documents that are referenced in the required training activities for new professional staff include:

[Topics Relevant to MIHP Practice](#)

[Root Causes of Infant Mortality](#)

Health Disparities Definitions

#### **4. Required Training for Waiver Staff**

For information on training requirements for waiver staff, see *Chapter 6 - Becoming an MIHP Provider*. Go to the sub-section titled, *Staffing Waiver Requests*.

#### **5. Required Regional Face-to-face Coordinator Meetings**

Regional face-to-face coordinator meetings are held twice a year in the spring and fall at four different locations around the state. The coordinator or designated alternate **must** attend this two-day meeting at their location of choice. Two persons from each MIHP can participate. Meetings generally cover program updates, Medicaid updates, and training on one or more critical topics. They also offer useful networking opportunities for participants. CEs are offered for some of the trainings conducted at the meetings. The decision to conduct regional meetings rather than one statewide meeting was made to save travel time and costs for coordinators and to allow for more interaction among participants.

Coordinator meeting participants who are present for the entire two-days receive training certificates. The coordinator or the coordinator's alternate must maintain proof of participation in all MIHP required regional face-to-face coordinator meetings. It is important to carefully file each training certificate. If you lose a training certificate, there may be a fee to replace it.

Certificates documenting participation of at least one staff (coordinator or alternate) are required at the time of certification review. If these certificates are not presented to the reviewer, the training indicator (#44) will be rated as *Not Met*. Participants must stay for the entire two days in order to receive the certificate. There are no exceptions. For this reason, it is best to have two staff participate in each meeting in case one becomes ill or has an emergency. If only one staff plans to attend, there should be a back-up staff who can participate in case of an emergency.

PowerPoint presentations and other resources from the required face-to-face coordinator meetings are available at <https://events.mphi.org/mihp>.

#### **6. Special Meetings and Trainings**

Special meetings are sometimes held with key partners, such as Medicaid Health Plans, to better collaborate in serving our mutual target population.

At times, providers are invited to attend special events sponsored by other initiatives, such the Infant Mortality Summit or the Michigan Home Visiting Conference. These are optional, but providers are encouraged to participate, if possible.

#### **7. MIHP Provider Network Regional Meetings**

In several regions of the state, MIHP providers meet together on their own to develop relationships, coordinate referrals, and share mutually beneficial information. MDHHS encourages providers to participate in these networks, if possible. Contact your consultant to find out if there is a network in your region.

## 8. Home Visiting Collaboratives

In a few areas of the state, representatives from different home visiting programs (e.g., MIHP, Nurse-Family Partnership, Healthy Families America, Early Head Start Home-Based Option, Parents as Teachers, Healthy Start, etc.) meet together to create local home visiting systems, sometimes referred to as “hubs.” The goal is to better serve the needs of families across programs and avoid duplication of services. MDHHS encourages participation in these efforts, if possible, as MIHP has a clear stake in home visiting systems-building at the state and local levels.

## 9. Maternal and Child Health Newsletters

It is suggested that you subscribe to the following online newsletters to keep current with maternal and child health developments at the national and state levels:

*Association of Maternal and Child Health Programs (AMCHP)*

[AMCHP Pulse](#)

*Michigan Council for Maternal & Child Health*

Friday Notes E-Newsletter

Send an email requesting to [info@mcmch.org](mailto:info@mcmch.org)

## MIHP Program Coordinator Responsibility for Disseminating MIHP Information to Staff

The MIHP program coordinator is responsible for disseminating information received from the MIHP state team to their professional and administrative staff. All staff working across the state must access and use this information in order to promote fidelity to the model and improve the quality of MIHP services. This is a critical responsibility that the program coordinator must take very seriously. At a minimum, the program coordinator must:

1. Forward every coordinator email, in its entirety, to all professional staff upon receipt.
2. Share with staff the updates and training content information received at regional coordinator meetings. This means supplying staff with copies of the handouts, reviewing PPT slides with staff, and addressing staff questions about the information.
3. Inform staff of any other special communications, webinar announcements, etc.

## SECTION 11 - MAINTENANCE, RETENTION AND TRANSFER OF MIHP RECORDS

### Maintenance of Records

In the *Medicaid Provider Manual Chapter General Information for Providers (15.4 Availability of Records and 15.7 Clinical Records)*, there is discussion of the expectations for maintenance of clinical records. *15.4 Availability of Records*, discusses making records available to authorized agents of the state (consultants, reviewers, Office of Inspector General, etc.) for examination through the method determined by the agent. When MDHHS personnel or authorized agents want to see the chart, the agency must provide the entire chart. MIHP providers are expected to adhere to policy.

The MIHP agency should have a single, complete chart for each beneficiary that contains all applicable MIHP forms. The chart must be accessible to all agency staff who are serving the beneficiary and to agents of the State and federal government upon request at any time, not only at the time of certification review. For this reason, and in order to reduce the likelihood that the beneficiary's chart will be lost or stolen, the chart should not be taken from the office. Agencies may choose to have a working chart with copies of forms, but the official chart should be complete and remain in the office.

It is highly recommended, not required, that all open charts be maintained in a single format (paper or electronic). All closed charts should be in one format or the other.

Handwritten documentation in charts must be legible.

The state database is not an acceptable form of storage for beneficiary records. Agencies are required to store their own electronic *Risk Identifiers* and *Discharge Summaries*. An agency with an EMR system must do a file transfer from the MILogin System back into their electronic record, or print these documents off and scan them into their record.

### Retention of Records

State law requires closed health records (including MIHP records) to be kept in their entirety for seven years after the last date of service. MIHP providers must keep all closed records in a HIPAA-compliant secure area for seven years, even if they are no longer operating as an MIHP. All accounting records relating to health records must be identified and kept with health records. Health and accounting records must be available for inspection and/or audit by MDHHS, including MIHP program staff, Medicaid staff and Office of the Inspector General staff.

The MDHHS Office of Inspector General (OIG) regularly conducts investigations of open and closed MIHP agencies. If the OIG finds that closed records are not maintained as described above, the agency (or the responsible party if the agency is closed), may be required to reimburse the State of Michigan for past payments received.

The *Medicaid Provider Manual Chapter General Information for Providers* discusses the maintenance of health records. The Michigan Public Health Code 368 of 1978 Sec. 333.16213 outlines Michigan law pertaining to medical record retention, transfer of medical records, destruction of records, and the process for handling record requests.

Providers should be very familiar with these requirements. To access Section 333.16213 of the Michigan Public Health Code, go to:

[http://www.legislature.mi.gov/\(S\(cc3ll0exiqr5ch2gt42o4rjo\)\)/mileg.aspx?page=GetObject&objectname=mcl-333-16213](http://www.legislature.mi.gov/(S(cc3ll0exiqr5ch2gt42o4rjo))/mileg.aspx?page=GetObject&objectname=mcl-333-16213)

## Transfer of Care/Records

On occasion, a beneficiary will ask to be transferred from one MIHP agency to another. When this happens, it is expected that both the transferring and receiving agencies will talk with her about the request and encourage her to stay with the program of origin, if appropriate. It also is expected that the transferring and receiving agencies will communicate with each other appropriately and professionally in order to expedite the transfer in the beneficiary's best interest.

When an agency receives a transfer request, they may not refuse to transfer the beneficiary. Furthermore, the transferring agency must not bill for any visits conducted after the date that the transfer request was received.

When the beneficiary requests a transfer, she must sign the *Consent to Transfer MIHP Record to a Different Provider (Consent to Release Protected Health Information)*. The transferring agency must keep this signed form on file after the beneficiary information is sent to the receiving agency. The receiving agency must also keep a copy of the signed *Consent to Transfer* form on file. If the beneficiary does not sign this form, her MIHP records will not be transferred to the new provider and she will not receive MIHP services.

When sending a request for transfer, the receiving agency must keep the fax transmission confirmation form, verifying that the fax was sent. When sending the required beneficiary documentation to the receiving agency, the transferring agency must keep the fax transmission confirmation form, verifying that the documentation was sent. Fax transmission confirmation forms may be filed in the beneficiary's chart or be filed together in a binder.

## Transferring Agency

When a request for transfer is received, the transferring agency has 10 working days to send or fax copies of all appropriate documents to the receiving MIHP agency. At a minimum, these documents must be transferred:

1. *Risk Identifier*
2. *Risk Identifier Score Summary*
3. *POC, Parts 1-3*
4. *Professional Visit Progress Notes*

If a mother consents to transfer "my infant's health information" but not "my health information," the transferring agency is still expected to transfer both the maternal and infant components of the *Infant Risk Identifier* in their entirety, along with the corresponding *POCs*, to the receiving agency. If the mother objects to this, she will not be served by the new agency.

The transferring agency does not:

1. Copy its consent forms and send them to the receiving agency, as the opening date remains the date that the *Risk Identifier* was administered by the transferring agency.
2. Complete a *Discharge Summary*, as it would have to be deleted in order for the receiving agency to continue services.

## Receiving Agency

The receiving agency must obtain the beneficiary's information from the transferring agency before providing services to the beneficiary, except in an emergency situation (e.g., family is homeless, has no food, etc.). This emergency must be documented in the chart.

If the receiving agency does not obtain the beneficiary's information within 10 working days, they must document their efforts to get the information from the transferring provider and contact their consultant. The consultant will instruct the transferring provider to release the documents. If the transferring agency does not comply immediately, the consultant may be able to get the *Risk Identifier* and *Score Summary* from the database and send copies to the receiving agency. As long as there is documentation that the consultant has been contacted, the receiving agency will not be penalized by the certification reviewer because the documents, which should have been transferred, are not on file.

The receiving agency:

1. Must obtain a new signed *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and a new signed *Consent to Release Protected Health Information* from the beneficiary.
2. Must use the *Maternal and Infant Forms Checklist for Transfers Received*, identifying the new case manager.
3. Must notify the medical care provider and MHP that they are now serving the beneficiary.
4. Is not required to sign the *POC 1* or *POC 3*.
5. Must determine if the transferring agency pulled all of the risk domains that scored out on the *Risk Identifier Score Summary* when the *POC 2* was originally developed. If any domains were missed:
  - a. Add them to the *POC 2* and indicate the date they were added in Column 1.
  - b. On the *Contact Log*, document that the domains have been added because they were missed when the original *POC 2* was developed.
  - c. Update the *POC 3* to document the added domains and obtain RN and SW signatures, as always.
  - d. When you notify the medical care provider that the beneficiary has transferred to your MIHP, use the Prenatal or Infant Care Communication form, check "Status Update" at the top, and note the risk domains that have been added to the *POC 2*.

The agency that originally entered the *Risk Identifier* into the state database (MILogin System) will continue to be noted as the agency that completed that specific document in the database. Although the name of the transferring MIHP agency is noted on the *Risk Identifier*, this does not prohibit the receiving MIHP agency from serving the beneficiary, billing for visits and completing the *Discharge Summary*.

When a beneficiary has signed a transfer but then declines to transfer, the original agency must secure a statement in writing from the beneficiary indicating that she has rescinded her transfer request.

## Failure to Transfer Records within 10 Working Days

Providers that fail to transfer the complete set of records within 10 working days, or that provide any additional billable services after a transfer request has been received, are monitored at the state level. If a provider demonstrates a pattern of failing to transfer records or providing services after a request has

been received, it may be determined that the provider is not providing acceptable services as defined by Medicaid.

Service acceptability is discussed in *Section 8.5 Service Acceptability, General Information for Providers Chapter, Medicaid Provider Manual*. This section outlines situations in which service is not acceptable. If Medicaid determines that the provider is not in compliance with service acceptability requirements, it may result in the provider's disenrollment from Medicaid.

### **Transferring the Beneficiary after the Discharge Summary Has Been Entered**

There are times when a provider will receive a transfer request on a maternal or infant beneficiary who has already been discharged, but had unused visits. For example, an infant is discharged after the initial 9 visits were conducted and the *Discharge Summary* is entered into the database, but then the mother finds out that her infant may be eligible for an additional 9 visits with medical care provider authorization.

This is a valid request to transfer and it must be honored by the first agency. The first agency must comply with all of the requirements related to transfer. Records must be sent within 10 working days of receipt of the transfer request and the *Discharge Summary* must be deleted within 10 working days of the receipt of the transfer request.

### **Warm Transfer**

It's expected that agencies will implement a warm transfer with beneficiaries who transfer from one MIHP agency to another. A warm transfer can be defined as a situation in which MIHP staff transfers a beneficiary to a new MIHP, but assists with introduction and sharing of information about the beneficiary's needs during the transfer process.

Warm transfer techniques may also be used when making a referral to another social service or medical agency for assistance. In that case, the MIHP staff may either conference the call to facilitate a three-way discussion or instead the MIHP staff may choose to initiate the call then "drop off" the line allowing the beneficiary to discuss his or her situation with the third party individual privately.

The warm transfer process is designed to streamline intake, referral and assistance. The initial agency performs a warm transfer to ensure the beneficiary receives the most appropriate information to meet their needs. This process allows the initial agency to stay on the line to ensure the second entity can help the consumer. Also, the referring agency can assist the consumer by helping them explain their needs to the second entity.

## SECTION 12 - MIHP TERMINATION OF SERVICES

### Termination

There are two ways that MIHP services are terminated. Services can be terminated voluntarily by the provider or as a result of decertification by MDHHS:

#### MIHP Provider Voluntary Termination

When an agency no longer wishes to provide MIHP services and decides to terminate their program, the agency must follow the steps outlined in the *MIHP Termination Protocol*. The protocol is posted on the MIHP website.

The agency must submit to MDHHS a written notice to terminate which:

- Details their intent to follow the MIHP termination protocol.
- Cites a termination date not less than thirty days in advance of the date of notification.
- Includes the agency's MIHP NPI number.

The provider must also submit a plan describing:

- How and when beneficiaries, MHPs and other MIHP providers will be notified.
- How beneficiaries will be transferred to other MIHP providers.
- How the provider will maintain beneficiary records in keeping with HIPAA requirements.

MDHHS may make a site visit to observe the termination process and provide consultation on problems that may arise. Within thirty days after the termination date, the former provider must send a communication to MDHHS detailing compliance with the termination protocol.

Terminated providers may bill CHAMPs for up to one year from each beneficiary's last date of service if the date of service occurred prior to termination date.

#### MIHP Provider Decertification

An agency that is decertified and terminated by MDHHS must follow the *MIHP Decertification Termination Protocol*. In this case, the termination date is determined by MDHHS, not by the agency. The protocol is posted on the MIHP website.

### MIHP Provider Voluntary Inactive Status

Only an MIHP agency with current full certification status may opt to become voluntarily inactive. This means that an MIHP agency in good certification standing and in business for a minimum of six months may choose to temporarily discontinue MIHP services for a minimum of six months and a maximum of 12 months when extenuating circumstances arise and the agency is unable to provide professional visits. An agency with conditional certification status is not allowed to choose this option. An agency that chooses voluntary inactive status must follow the *MIHP Provider Termination Protocol* and is approved at the discretion of the MDHHS. The protocol is posted on the MIHP website.

## SECTION 13 - REPORTING MEDICAID BILLING FRAUD, HIPAA VIOLATIONS, AND QUALITY OF CARE CONCERNS

Any provider, employee, or beneficiary who suspects Medicaid billing fraud, patient abuse, or violation of HIPAA privacy regulations is encouraged to contact MDHHS. The phone numbers to use for reporting are given at the end of the [Medicaid Provider Manual](#) in the Directory Appendix under, “Reporting Fraud, Abuse or Misuse of Services.” The numbers that may be of most use to MIHP providers are given below.

### To report suspected Medicaid provider fraud and/or abuse:

Office of Inspector General

1-855-MI-FRAUD (643-7283) Toll free

[http://www.michigan.gov/MDHHS/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-220188--,00.html](http://www.michigan.gov/MDHHS/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html)

#### Examples of Medicaid Provider Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports
- Falsely charging for:
  - Missed appointments
  - Unnecessary medical tests
  - Telephoned services

### To report quality of care concerns or suspected HIPAA violations regarding an MIHP provider:

MDHHS MIHP Consultant, MDHHS Division of Maternal and Infant Health. Consultant contact information is provided in *Chapter 1 – Introduction to MIHP Services*. The MDHHS MIHP consultant will explore the situation and take action, as indicated.

### To report complaints about a licensed healthcare professional (e.g., licensed registered nurse, licensed social worker, etc.):

Bureau of Health Services, Allegations Section

517 373-9196

[http://www.michigan.gov/lara/0,4601,7-154-72600\\_73836---,00.html](http://www.michigan.gov/lara/0,4601,7-154-72600_73836---,00.html)

A publication titled *Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians* (July 2014), is pertinent to Medicare and other federal health care providers.

To access the document, click here:

[Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians.](#)

## SECTION 14 - REQUIRED MIHP FORMS

MIHP providers are required to use standardized forms which were designed to increase efficiency and promote consistency across the state. All of the required and optional MIHP forms are available at [www.michigan.gov/mihp](http://www.michigan.gov/mihp).

Because the forms were developed to prompt concise, systematic record-keeping, check-boxes are provided wherever possible and space for narrative comments is limited. By checking a box, the professional who signs the form is stating that he or she took a specific action.

MIHP forms are revised as a group annually. At that time, the date is changed on **all** of the forms, even those that were not modified in any other way.

If a single form must be revised before the next annual release, the same document name and date is used, but the revision number and date is added. As long as you are using the forms with the correct original date, regardless of the version date, you will be in compliance at your certification review.

Whenever one or more forms are revised or a new form is introduced, you will be notified via a coordinator email message.

You must use the appropriately dated versions of the required standardized forms. You are not required to use newly-issued forms in charts that are currently open; you are only required to use them in charts that are opened on or after the date of the forms.

The vast majority of MIHP forms are required. If an MIHP form is optional, it is stated as such on the form and in the form instructions.

### Assuring that Staff Are Using the Forms Correctly

All staff must be trained to use the forms as required by MDHHS. Documentation on all forms must be complete and accurate. It is the coordinator's responsibility to ensure that all staff:

1. Have ready access to the forms instructions, which are posted at the website.
2. Receive ongoing feedback on completing the forms subsequent to internal QA activities.

### General Instructions for Using the MIHP Forms

General instructions for using the MIHP forms are as follows:

1. Forms are available in protected Word format. The intent is that all MIHP agencies are using standardized forms.
2. You can add your agency name, address and patient ID labels to paper forms without asking for MDHHS approval. This may be done in any non-electronic way (e.g., typing, handwriting, affixing labels, stamping, etc.).
3. Any other proposed additions to electronic forms must be submitted to and approved by the MDHHS. Generally speaking, you cannot subtract a data field from a form and data fields must be in same order as on the standardized form. MDHHS may allow you to add content to a standardized form in some unique situations, but not if it deviates from the intent of the form.
4. Although you may not add to or change MIHP required or optional forms electronically, you may develop and use your own supplementary forms, or forms developed by others.

5. There is no standardized demographic sheet (beneficiary name, address, phone, FOB's name, etc.), but you can develop your own.
6. The Social Security Number (SSN) box on some forms is there as a means of identifying Medicaid beneficiaries.
7. Data entries on forms cannot be inappropriately altered. If a correction is necessary, there must be a single line through the error with the initials of the person responsible for the error. The alteration must be visible; no white-out, permanent markers or scribbling may be used to make the original entry illegible. If a data entry is added, rather than corrected, it must also be initialed. You also may date the correction or addition if that is your preference, but it is not required.
8. Only the professional who conducts a professional visit can sign the *Professional Visit Progress Note (PVPN)* or edit the PVPN after the fact. It is not appropriate for another individual, such as the MIHP program coordinator or a QA coordinator, to delete or add entries to the PVPN. If the MIHP program coordinator or internal QA coordinator wishes to comment on a particular PVPN upon review, that individual may attach an addendum to the PVPN.
9. The professional who conducts a professional visit may dictate the PVPN entries to another staff who completes the form, but the professional must review the note carefully before signing it.
10. When signing MIHP forms, it is acceptable to use the first initial and full last name.
11. You may use electronic signatures on forms that are filed in paper charts, as long as they are password protected. This applies to all MIHP forms requiring signatures, including the *Professional Visit Progress Note (PVPN)*. There must be verification of a secured log-in for typed signatures. When you type a signature on a paper form, you are converting it to an electronic form, even if it's in a paper chart, so answers to questions 1 – 3 at the end of this chapter apply. It is not acceptable to type a signature on a form without verification of a secured log-in.
12. When documenting your professional credentials on MIHP forms, your licensure should be indicated as one or more of the following:
 

RN	Registered Nurse
LLBSW	Limited Licensed Bachelor's Social Worker
LLMSW	Limited License Master's Social Worker
LBSW	Licensed Bachelor's Social Worker
LMSW	Licensed Master's Social Worker
IBCLC	International Board Certified Lactation Consultant
13. You can use a signature stamp on letters, but not on other MIHP forms.
14. Different MIHP forms must be completed by specified deadlines. See the MIHP website for a chart titled *MIHP Cycle 7 Required Timelines*.
15. It is acceptable for agencies to use e-fax to transmit MIHP forms. E-fax allows you to send and receive faxes over the Internet from any device with email access (computer, tablet, phone, etc.), rather than via fax machine and phone. An agency receives a log of e-faxes that were sent. If the log is maintained in a computer, this would suffice for certification review purposes.
16. It is preferred that staff use complete words in *Professional Visit Progress Notes*, however, industry-standard abbreviations are acceptable such as Dx, Tx, DOB, EDC., etc. It is recommended that you keep a master list of abbreviations so all staff are using them the same way.

17. You may choose to insert “NA” in any data field on any form, as appropriate, or to leave the field blank. Some agencies instruct their staff to use “NA” to indicate that a data entry was not inadvertently omitted.
18. There are some requirements for paper charts that do not pertain to electronic medical records. For example, in paper charts, the beneficiary’s name is required on each page of the *PVPN*, but the name is not required on each page of electronic *PVPNs*.

## SECTION 15 - INFORMATION AND RESOURCES

### Michigan's Home Visiting Programs

MIHP is one of several early childhood home visiting models being implemented in Michigan. Home visiting programs provide voluntary, in-home services to expectant parents and families with infants and young children. Home visiting services include education, support and case management. They are intended to prevent a wide range of negative child outcomes by promoting maternal and child health, school success, positive parenting practices, safe home environments and access to services.

Home visiting programs vary with respect to the age of the child, the risk status of the family, the program goals, the range of services offered, the intensity of the home visits, the content of the curriculum or interventions delivered, the professionals or paraprofessionals who provide services, how effectively the program is implemented, and the range of outcomes observed. Quality home visiting programs have been shown to lead to outcomes such as improved prenatal health, increased intervals between births, reduced child maltreatment, improved school readiness, and increased family self-sufficiency.

### Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)

A new focus on home visiting transpired in 2010, when the federal Patient Protection and Affordable Care Act (2010) was signed into law. Section 511 of this law amended Title V of the Social Security Act to authorize the creation of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), which allows collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

MIECHV funds the states to implement home visiting programs that the federal Department of Health and Human Services has reviewed and designated as evidence-based. To date, 19 home visiting models have been so designated. For information on these models, go to the Home Visiting Evidence of Effectiveness (HomVEE) website at <http://homvee.acf.hhs.gov/programs.aspx>.

The overall goal of Michigan's MIECHV initiative is to improve child and family outcomes by implementing evidence-based home visiting within the Great Start System that provides programs for pregnant women, parents and caregivers, and children from birth to 8 years of age.

Michigan has chosen to use MIECHV funds to support the evidence-based models:

1. Healthy Families America
2. Nurse-Family Partnership
3. Early Head Start – Home-based Option

For information on these models, go to the MDHHS MIECHV website at [Home Visiting – MIECHV Projects - State of Michigan](#) or to the HomVEE site at <http://homvee.acf.hhs.gov/programs.aspx>.

### Michigan Public Act 291 of 2012

In 2012, Michigan enacted a law (Public Act 291) requiring the Michigan Departments of Community Health, Human Services and Education to only support home visiting programs that are evidence based. MIHP and the MIECHV-funded models meet the evidence-based criteria specified in the law for designation as an evidence-based program. Infant Mental Health and Healthy Start meet the criteria for promising programs.

## Recommended MDHHS Resources

It is strongly recommended that all providers and MIHP staff become familiar with the evidence-based resources below.

### Michigan Safe Delivery

[MDHHS - Safe Delivery](#) Safe Delivery Hotline: 866-733-7733

Safe Delivery allows parents to safely surrender their newborn child no more than 72 hours old to an employee who is inside and on duty at any hospital, fire department, police station, or by calling 911. This program is a safe, legal and anonymous alternative to abandonment or infanticide and releases the newborn for placement with an adoptive family.

### Oral Health for Pregnant Women and Infants

[MDHHS Oral Health Website](#)

Dental caries (also commonly referred to as cavities) is a transmissible, infectious disease. Mothers or even other caregivers may unknowingly transfer caries causing bacteria to their children through the exchange of saliva, even before the first tooth develops. Michigan PRAMS data indicates that nearly half of Michigan women with an immediate dental need did not receive oral health care during their pregnancy, with minorities and low income women struggling the most.

The Department of Health and Human Services (DHHS) is dedicated to addressing these oral health disparity issues. It is estimated that children of mothers with untreated decay have four times the risk of decay compared with children of mothers without untreated decay. In addition, there is mounting research which indicates a potential link between preterm birth, low birth weight and poor oral health. Since pregnancy is a critical time in which women may be more likely to adopt healthy behaviors as well as gain needed dental health insurance coverage, it is imperative that oral health is prioritized during the perinatal period by medical and dental professionals, as well as the public health community at large.

Visit the MIHP website to obtain information on oral health for pregnant women and infants. Both written and video materials are available. Resource materials may be viewed, printed or copied. Materials are available in English and Spanish. You may obtain additional oral health resources at the following link:

### Zika Virus

The top MDHHS priority for the public health response to Zika is to protect pregnant women because of the risks associated with Zika virus infection during pregnancy. On an individual level, pregnant women can take actions to protect their pregnancy. It's important to remember that everyone can take action to protect their community from viruses spread by mosquitoes, like Zika.

For the latest information and Zika virus resource list:

1. <http://www.cdc.gov/zika/index.html>
2. <https://www.cdc.gov/vitalsigns/zika-babies/index.html>